Worcell

# AMERICAN

# JOURNAL OF INSANITY.

VOL. XXXVI. · JANUARY, 1880. No. 3.

UTICA, N. Y.
STATE LUNATIC ASYLUM.
JOHN WILEY & SON, Astor Place, New York.

Ellis H. Roberts & Co., Printers, 60 Genesee Street, Utica.

# TABLE OF CONTENTS.

# AMERICAN
# JOURNAL OF INSANITY,
## FOR JANUARY, 1880.

---

## RESPONSIBILITY OF ASYLUM SUPERINTENDENTS.

We print in this number, *in extenso*, the decision of Judge Shipman, of the Circuit Court, of the State of Michigan, in the case of *Newcomer vs. Van Deusen*, which has recently been terminated. It is certainly one of great interest to all members of the profession, as bringing up the test question of the legal liability of medical officers of the State, to any prosecutor who thinks he can convict them of a professional error of judgment. This decision may, perhaps, indicate some advance in the application of the law to such questions, and is really a considerable contribution to the science of Medical Jurisprudence, which must attract the attention of, and be quite welcome to the whole specialty.

The case is that of a woman, Mrs. Nancy J. Newcomer, of considerable experience in worldly mutations, who had been divorced from one husband, and had ceased to live with her second, after which she had studied medicine and become a homœopathic physician; had lost her eldest daughter by sudden death, and had also had a severe fall from a railroad train, becoming, as might not unreasonably be expected, gradually strange in her conduct, until her relations saw that she was unmistakably insane, and thereupon took the usual steps to place her in the asylum at Kalamazoo, of which Dr.

E. H. Van Deusen at that time was Superintendent. She was detained there from October 1, 1874, and taken away by her friends in August, 1875, improved, but not recovered. She afterwards brought suit against Dr. Van Deusen for false imprisonment and illegal detention, including also, we believe, charges of maltreatment, laying her damages at $40,000. The cause was tried in the Circuit Court, the jury giving their verdict for the plaintiff, and awarding $6,000 damages. The case was appealed to the Supreme Court, which reversed the judgment of the lower court for certain errors in the procedure, and remanded the case to the Circuit Court for a new trial. However, on the main question raised in the Supreme Court, *i. e.*, whether "good faith," in the action of receiving and detaining a patient, under the full belief that he is insane and requires the treatment of the institution, would be a sufficient *defense* to such a prosecution as this, the court was equally divided, and very naturally the counsel for the plaintiff claimed that the lower court was justified in its position that *good faith* was no defense; that the want of "due diligence," (extraordinary diligence?) was the same as "negligence."

The Supreme Court agreed as to certain defects in the proceedings below, which made it necessary to grant a new trial, but were divided on the question whether a person might be arrested anywhere by his friends, on the claim that such person was insane, and taken to an asylum, without public or judicial action, and detained there on the judgment or discretion of the superintendent, from personal examination of the patient, and the facts of previous history submitted by the parties bringing such patient. The court in this case, of course, had no reference to the liability or peril of the parties making such arrest and taking the patient to

the asylum, but confined itself to the question of the responsibility of the superintendent in thus receiving and detaining such patient at the request of his friends.

The opinion of two of the four judges is very decided in favor of the superintendent's exemption from liability in such a case, interpreting the law of Michigan to be, that persons having means for their own support may be received simply upon the "request" of their friends, without the order or certificate of any public official. We give the main question as stated by the two judges, Marston and Graves, in this case, and a salient portion of their argument.

"There are many instances where, without a judgment or process of a court, an act may be done, but at the peril of the person acting, who, when called to account therefor, assumes the burthen of proving that he was justified in what he did, and the same rule might apply in this class of cases where the friends or relatives act upon their own responsibility. But where a person is brought to the asylum by, or at the request of his relatives, would the superintendent thereof, who, after a careful investigation of the patient, in good faith, and a belief based thereon, that, he was, in fact, insane, act at his peril in receiving, detaining and treating him thereafter? I am clearly of the opinion that he would not be liable, under such circumstances, even although it should be made to appear that the person received was not insane. The good faith of the superintendent must be to him a protection, as it is at least questionable whether in very many cases he can have any other. The judgment of a court sentencing a person to imprisonment as a punishment for an offense of which he has been found guilty, and the execution issued thereon, prescribe a definite period, at the expiration of which, but not before, the person is entitled to his liberty, and no reformation of character which he may undergo in the meantime, will

entitle him to his liberty one day sooner, except under some special statutory provision; and the person under whose care he is placed can, under no circumstances, be held liable for false imprisonment in detaining him the full period of time mentioned in the warrant of commitment. Not so, however, is the case of a person sent to the insane asylum. If sent there by the Superintendents of the Poor, or by the Probate Judge, no definite time is by them fixed for his detention. He is to be received to remain there "until he shall be restored to soundness of mind," and not a single day or hour longer can he be detained against his will. But who shall determine the fact that he has been restored to soundness of mind? Where the patient is convalescent it may be a matter of considerable nicety, and about which competent persons might differ in opinion, as to the exact time when soundness was restored. During such a period, does the superintendent, acting in good faith, with a full knowledge of the condition of the patient, and firmly believing that soundness of mind is not fully restored, act at his peril in detaining him? Or, in a case where the Probate Judge has had an examination, and a jury has determined that the person is insane, and he is sent to the asylum as an indigent insane person, under the certificate of the Probate Judge, but the superintendent, on his arrival, believes, after an examination, that the person is not and has not been insane, would he be justified in receiving and retaining him under such circumstances? He would have the verdict of a jury, rendered, perhaps, the very same day, declaring the person insane, who he believed was not. Surely that might seem a protection, but would it be? Must not the superintendent, in all these cases, act in accordance with his own belief? Can he be given any other guide? And if he errs, which is possible, shall he for such error of judgment, notwithstanding the fact that his motives were pure and praiseworthy, be held liable in damages therefor? If so, then he acts in a most difficult and dangerous position. He acts not alone at the peril of the person being insane in fact, or that soundness of mind has not been fully restored, but

that a jury will so find upon a trial had, months or even years afterward, when the person is acknowledged by all to be no longer insane—when all the facts and circumstances which were daily seen by the superintendent and his assistants, and which satisfied him and them of insanity at the time, can no longer be seen or presented to the jury with all their force, while the supposed sufferings of the patient while there, proper if insane, but not if sane, will be presented in strong contrast to arouse their sympathies. Under such circumstances we might find the superintendent of the State Insane Asylum held responsible in damages for detaining a person, who was insane in fact, but who a jury, upon an investigation made long afterwards, should determine had not been so. Things equally unlikely and improbable have happened.

This would not, however, be the full extent of the dangers he would run. He is the head of the institution, and has "the direction and control of all persons therein," and it was made his special duty to "daily ascertain the condition of all the patients, and prescribe their treatment." Now, no matter how clearly his duties may have been prescribed, yet, owing to the large number of patients in such an institution, a personal examination of them daily, to ascertain their condition and prescribe for their treatment, would be beyond the power of any one man to perform. Much of this labor must, from the very necessities which exist, be performed by others, whom the superintendent would not have the sole power of appointing and discharging, and yet for their errors and mistakes of judgment, he must be held responsible. Such an extended liability as is claimed in this case, would operate as a perpetual bar to any person possessing the necessary qualifications for the position accepting the same, and would soon leave the institution at the mercy of men of no character, responsibility or experience. Under such a rule, the legislature with all its power could not carry out the constitutional injunction to foster such institutions for the benefit of those inhabitants who are insane. Under the view taken, will the liberty of the

citizens be sufficiently protected? I think so. The Michigan Asylum for the Insane is not a private, but a public institution. Its Medical Superintendent and his assistants do not receive fees or a salary in any way dependent upon the number of inmates. They receive a fixed salary, paid out of the State treasury, so that they can have no motive other than a proper one in an increase in the number of inmates in the Institution; and should any one of them, for corrupt purposes, receive or attempt to detain any person improperly, it would be promptly discovered by some of the officers, unless all were alike corrupt, and interested in his detention, something which is very unlikely to occur. Besides this, the statute provides for the appointment of trustees by the governor, by and with the advice and consent of the senate, to whom are given the government and sole and exclusive control of the asylum. They are to see that its design is carried into effect, and everything done faithfully, according to the requirements of the Legislature and the by-laws and rules of the institution. They fix the salaries and allowances of the officers; they establish by-laws; they are to ordain and enforce a suitable system of rules and regulations for the government, discipline and management of the asylum. They are to keep a record of their doings open at all times to the inspection of the governor, and of all persons whom he or either house of the Legislature may appoint to examine the same. It is their duty to maintain an effective inspection of the asylum. A committee of their number, for such purpose, is required to visit it every month, a majority of the board once every quarter, and the whole board once a year. They are to keep a record of the date of each visit, and the condition of the house and patients, and the result of their inspections is to be submitted to the Legislature, in January of each alternate year. It is true, notwithstanding these and all other safeguards which have or may be thrown around this institution, that abuses may exist and pass unnoticed. So it is, however, with all human institutions—the power given them may be abused. At some point there must be a

presumption that official duties will be properly performed, and I do not see why we may not presume that these officers and trustees will honorably and conscientiously perform their several duties, and prevent this, one of the most charitable and beneficent of our great State institutions, from becoming a prison, or aught else than that for which it was designed. No matter what safeguards may be provided as to a determination of the question of insanity, in the first instance, before the patient can be received, and which might exempt the superintendent from all liability in receiving him, the question as to his detention must still be left open, unless the good faith of the superintendent will protect him in detaining a patient until soundness of mind, in his opinion, be restored. I can imagine no possible way in which he can be guarded against actions brought and damages recovered by persons claiming that they have been detained longer than was necessary for their complete restoration. If good faith would be a defense in such a case, I can discover no good reason why it should not in all others. No valid reason, in my opinion, exists for any such distinction. Neither in the receiving nor in the detention of an insane person can his consent be required. Consent would imply sanity. The consent of an insane person, incapable in law of consenting, can not be required as a condition precedent in either event. To hold the superintendent liable for an error in judgment, or still worse, where he was clearly right, although a jury might be of a contrary opinion, would, in my opinion, entirely destroy the usefulness of this institution, by preventing anyone, possessing the necessary qualifications, from accepting the position. Patients convalescent, but before soundness of mind was fully restored, would be discharged only to suffer a relapse. Continued complaints would be made that patients were treated as insane, who were not, in fact; or that they were being detained longer than they should be, and suits innumerable, harassing to the superintendent, with a tendency to bring the institution into disrepute, and impair its usefulness, would follow, with a result easily foreseen. In my

opinion the key to the entire difficulty must be found in the good faith of the superintendent. This implies and requires a careful, conscientious discharge of all the various duties assigned him under the laws, rules and regulations of the institution. If all this he has faithfully observed he should not be held liable to respond in damages for error of judgment or mistake. If, however, he acts in a careless and negligent manner, indifferent as to whom he receives or detains, or as to the treatment they receive, or corruptly, in improperly receiving or unduly detaining any person brought there, for all such he should be held to a strict and rigid responsibility. This, in connection with the safeguard already referred to, will, in my opinion, reduce the dangers of abuse to the lowest possible degree. It will tend to increase, and not impair the usefulness of the asylum. While a difference of opinion exists among members of this court as to some of the above propositions, yet all are agreed that the court erred upon the trial, and that for the reasons hereinafter stated there must be a new trial."

The third member of the court, Judge Cooley, gave an opinion somewhat less luminous, admitting that it was not always essential to have a judicial determination before sending a person to an asylum, but that prudence dictates it, where there can be any doubt as to the actual fact of insanity, or where the person is harmless or not dangerous. He dwelt upon the liability to abuse of such a power, though he admitted the system had so far worked well; but in view of the fact that the door of the medical profession is thrown wide open to persons of every degree of knowledge or ignorance, he thought it was too great a power to be entrusted even to a professional man; for so subtle are the distinctions on this subject, that it was not impossible for a patient, brought to an asylum, by cunning management to have his captor detained there instead of

himself! The judge admitted that "during all the time Mrs. Newcomer was in the Asylum, Dr. Van Deusen had reason to believe that he was detaining her there in accordance with the desire of her family, and because she was insane," and that "if she was insane in fact, he was justified in so detaining her for her own benefit, and with a view to medical treatment, under the facts as they were made known to him." He could not, however, agree with the defense, that even if she were *sane*, and he acted in good faith, he would not be responsible, for *somebody* must be responsible. He would not be responsible for what *others* had done, but as this office, in his opinion, is partly ministerial and partly judicial, and the judicial function comes in play at a later period, on the question of duration of detention, and not at the outset in consigning a patient to the wards, so, as a sheriff is liable for a mistake by ignorance or malice, a superintendent also must bear the consequences when another has suffered from his ignorance or malice, though "exempt when he has acted in good faith."

This distinction is exceedingly fine drawn; but perhaps what it amounts to is only what the two judges, Marston and Graves, had laid down at the close of their opinion, that when a person has acted in a careless, negligent or corrupt manner, he may be held.

The fourth judge, Hon. J. V. Campbell, agreed with Judge Cooley on the main legal questions, and added that under the law of Michigan, which made no provision as to the reception of private patients, the superintendents must act only on their Common Law responsibility. He simply argued that there *should be* a summary procedure for determining the fact of insanity, if sane people are not to be deprived of legal protection. There must be actual ascertained insanity, or else *consent*, to justify seclusion. Dr. Van Deusen

was justified if Mrs. Newcomer was *insane*, or made no objection. If she was sane he was not responsible for the acts of her relatives, or anything beyond his own acts, and therefore should not have been treated as involved with them. Judge Campbell's opinion concluded as follows:

"The rules and regulations were all shown beyond dispute to be proper, and if any other person in the asylum, without his procurement, did acts of an improper character, he can not be bound to respond for them. There was no evidence legally tending to show conspiracy or bad faith in plaintiff in error, and the testimony of insanity was very strong. And I can not avoid the belief that unless the jury had been instructed that Mrs. Newcomer could not be confined unless dangerous, as well as insane, no verdict could have been rendered against Dr. Van Deusen."

On the new trial, Judge Shipman allowed the plaintiff to put in all her evidence, giving all opportunity to prove negligence, lack of good faith, abuse of his office, malice, conspiracy or what not, which it appears she utterly failed to do, the evidence of her insanity, and of Dr. Van Deusen's good faith in all his official action in the matter, being simply overwhelming. And so, before the defense completed the examination of their witnesses, the judge abruptly terminated the proceedings, declared that there was nothing to go to the jury, and charged the jury on the simple question of law, to find a verdict for the defendant. The opinion given with this charge is what we print, and we prefer to give it in full, to avoid the possible imputation of mistake or inadequacy, which a bare abstract or analysis might, in the opinion of some, incur. It will be seen that on the question that divided the Supreme Court, Judge Shipman cites the opinions only of those who were in the negative, and finds therein sufficient statements and ad-

missions of legal principles to warrant him in undertaking to give the casting vote, (so to speak), which should determine the scale in this case. The fact that the medical officer alone can determine the question of *improvement* or *recovery* after the patient has been committed, with all due forms of law, does, as Judge Shipman declares, "concede the whole controversy," and proves that the State officer does, so far forth, act in a *judicial*, not a mere ministerial capacity, and as so doing, is entitled to the protection of his privilege. It is nowhere denied that an officer acting in a *quasi*-judicial character, whose function is partly ministerial and partly judicial, may be liable for transcending his official duty, or for any abuse of his power; but where, as in this case, no malice or *mala fides* can be positively proved, the officer who acts as a professional man, according to the best of his judgment, is clearly entitled to the protection of the courts. The able Judge remarks that in Michigan there is no provision for any other judicial investigation into a case of insanity before it comes into the hands of a medical superintendent of the asylum. There is only the action of the relatives, the physicians and the superintendent of the poor. If that be the case we can only add that it renders more necessary an exact compliance with all the requirements of law in the preparation of papers, and the proceedings preliminary to admission. A technicality was not allowed to overrule justice in this case, but it is better to be even technically right.

Although we have said enough to introduce the judgment rendered by Judge Shipman, we must take advantage of this opportunity to reiterate the claims that we have before made for the superiority of our New York legislation on this subject, as removing all possible question of the security of the rights of the

citizen. As will have been seen, all that is absolutely necessary to make the opinions of the four Supreme Court Judges, in this case, perfectly harmonize, is the introduction of some *official* action in *every* case of a person held for insanity, *previous* to his commitment to an asylum. The whole difficulty in the case of Mrs. Newcomer, and the whole evil in the system as criticised by Judge Cooley, would have been obviated and cured, had the recent statutes of the State of New York on this subject been incorporated into the law of Michigan. In Michigan, as in England, for private patients, no legal recognition seems to be necessary—no order of any public officer, no medical certificate, nothing but a written "request," signed by a relative, friend or other person. All the remarks of the two dissenting judges, about liability to abuses, from incompetency or ignorance, from sordid or corrupt motives, placing the liberty of even sane persons in jeopardy, indicate dangers and defects which are not to be obviated by hedging about superintendents, or holding them to a degree of responsibility which would make their office impracticable. They simply connote defects and shortcomings in the law of commitment, which are fully met and remedied by such provisions as those in the law of New York, which we here give:

[Laws of New York, Chap. 446, Tit. I, Art. I, §§ 1, 2, 3.]

SECTION 1. No person shall be committed to or confined as a patient in any asylum, public or private, or in any institution, home or retreat for the care and treatment of the insane, except upon the certificate of two physicians, under oath, setting forth the insanity of such person. But no person shall be held in confinement in any such asylum for more than five days, unless within that time such certificate be approved by a judge or justice of a court record of the county or district in which the alleged lunatic resides, and said judge or justice may institute inquiry and take proofs as to any alleged lunacy before approving or disapproving

of such certificate, and said judge or justice may, in his discretion, call a jury in each case to determine the question of lunacy.

§ 2. It shall not be lawful for any physician to certify to the insanity of any person for the purpose of securing his commitment to an asylum, unless said physician be of reputable character, a graduate of some incorporated medical college, a permanent resident of the State, and shall have been in the actual practice of his profession for at least three years, and such qualifications shall be certified to by a judge of any court of record. No certificate of insanity shall be made except after a personal examination of the party alleged to be insane, and according to forms prescribed by the State Commissioner in Lunacy, and every such certificate shall bear date of not more than ten days prior to such commitment.

§ 3. It shall not be lawful for any physician to certify to the insanity of any person for the purpose of committing him to an asylum, of which said physician is either the superintendent, proprietor, an officer, or a regular professional attendant therein.

In these provisions it will be seen that the privilege and responsibility of the physician even is not "thrown wide open to everybody," but is restricted to such as can make good their professional character, are actual permanent residents, and have had at least three years' experience. It is hardly possible to conceive a surer or more complete safeguard for individual rights than we have here. It is certainly equal to anything provided for a person arrested on a criminal charge.

While contemplating the circumstances and issues of this trial, it is almost amusing to recall the rather loud and confident tone indulged in by certain persons, who boldly contrast the English system with ours, claiming great advantages and superiority in all respects for the former, hoping to impose upon the general public on the old principle of *omne ignotum pro mirifico.* We have seen what is the English practice in regard to the commitment of private patients, nearly identical with that of Michigan, as described in the case above, while pauper lunatics are sent on the order of a parochial

officer, accompanied by the certificate of *one* physician, with a statement or "history" of the case. We venture to say there is no comparison between the English and New York systems, as to the security and certainty obtained under the latter, as will be seen by examining the sections of the law of New York quoted above.

But without further preface we proceed to give the judgment rendered in this case, by Judge Shipman, of the Circuit Court, as his charge to the jury.

DECISION AND CHARGE.

*Nancy J. Newcomer vs. Edwin H. Van Deusen.*—"This action is brought by Mrs. Newcomer against the defendant to recover damages for an alleged false imprisonment of her in the Michigan Asylum for the Insane, at Kalamazoo, of which he was the Medical Superintendent. The cause has been once tried in the Circuit Court, and a verdict and judgment rendered against the defendant. This judgment was reversed by the Supreme Court, for various errors assigned to the proceedings, upon the trial by the defendant, and the cause remanded to this court for another trial, before a jury. Upon the questions arising, with one exception, all the judges of that court concurred, but upon the main question they were equally divided.

The facts briefly stated are these: October 1st, 1874, the plaintiff was sent to the Michigan Asylum for the Insane, at Kalamazoo, by her relatives, and delivered into the charge of the defendant, who was then the Medical Superintendent of the institution, as a patient for treatment in the asylum. She was a woman of considerable experience in life and in business matters. She had lived in several different States, and at times had carried on business for herself. She was also a physician, and to a certain extent had practiced as such. Her acquaintance with people and the ways of the world was larger than the average. She had been twice married, but obtained a divorce from her first husband and with the second she did not and had not

lived for some time previous to her going to the asylum. Although not then legally separated, they were, in fact, no more than friends to each other, he assuming and she conceding him none of the rights of a husband. By mutual consent he had nothing to do with her affairs. He has since obtained a divorce from her. For several months prior to July, 1874, she had resided in Toledo, Ohio, supporting herself, but during that summer she left the place and came to Calhoun county, in this State, where her daughter, mother, and two married sisters resided. She also had other acquaintances in that county and elsewhere in that vicinity. She remained in that part of the State until sent to the asylum by these relatives, none of the family, including her own daughter, objecting, while all knew of it, and her sister afterwards filled out answers to questions upon a blank provided by the authorities at the asylum, purporting to give the plaintiff's personal and family history, which was forwarded to the asylum. This instrument contained nothing to excite a suspicion that she was not insane, but on the contrary, presented corroborative evidence that she might be. She was received into the institution by the defendant, in the usual way, as a patient for treatment therein, and for no other purpose, and there she remained, to the knowledge, and with the consent and approval of her relatives, until discharged as convalescent, and taken home by them in August, 1875. She was taken there in the day-time, and by the usual public conveyances, without any attempt at concealment, and not under circumstances which would in any way invite or excite inquiry in those connected with the institution, nor was the conduct of her relatives, friends or others afterwards such as to direct the defendant's attention to her specially or to indicate that she was not a person requiring and having a right to receive treatment at the asylum.

The Michigan Asylum for the Insane is a hospital, founded by the Legislature of the State, in obedience to an express provision of the constitution itself, having a Board of Trustees to manage its concerns. The Trustees are required by law to appoint a medical and

assistant medical superintendent for the asylum; two assistant physicians and matron. It has about one hundred and fifty attendants and assistants and over four hundred and fifty patients. The various departments are under the immediate charge of supervisors, who see to the administration of medicines, and communicate with the physicians respecting the wants and condition of the patients. The matron has the general charge of the female inmates. Besides these it has various other officers connected with it, such as treasurer, steward and the like. The duties of the medical superintendent are quite extensive. He has the general charge of the buildings, grounds and farm, together with the furniture, fixtures and stock of the institution. He is the business manager of the entire concern and its chief executive officer, overseeing everything connected with the establishment, including the keeping of its accounts. Of necessity a very large portion of his time and attention must be devoted to other matters than the immediate care of patients, this work being entrusted largely to assistants. All admit that these officers are not, in any legal sense, his agents or servants, and that he is in no way responsible for their acts, except so far as he participates in them by directing them to be done. At the threshold of the case arises a question as to the extent of his responsibility for the seclusion of Mrs. Newcomer in the asylum, admitting him to be liable at all. The defendant received, examined and admitted her into the building, but that is all he did. He had no more to do about the immediate care, custody or treatment of her afterwards than with the acts of the engineer in heating the building. Much of the time she was there he was absent, attending to duties elsewhere, and some of the time not even in the State. Can it be said that the one act he did would necessarily, or even probably result in the plaintiff's being detained until August, 1875? The statute requires the patient's condition, as to sanity, to be ascertained daily, so that his determination, the first day, upon that fact, only determines what her treatment shall be until she should be again examined. Was not her detention after the

first day, in consequence of conclusions as to her mental condition arrived at by other officers appointed by law for that purpose, and with which he actually had nothing to do, since, if these officers concluded she was sane, either the second, or upon any subsequent day, she would then have been discharged? If Dr. Van Deusen be only liable for his own acts could he be held liable after that one act had spent its force, which it did the first day? Was not her detention afterwards the result of other agencies in which he took no part? Would he be more responsible for this part of her treatment, by his assistants, than for the result of medicines they might have prescribed, or other acts of theirs in regard to her, and with which it is admitted he can not be charged unless he took part in them?

The main question in the case, however, is deeper than this. All the damages which are claimed by Mrs. Newcomer, arose from acts which were done by the defendant, as medical superintendent of the asylum, and while acting officially as such within the line or limit of his duty, or by officers acting under him, as provided by the laws of the State. His skill as a physician, and experience in the treatment of the insane, appear in the proofs, and are denied by none, nor are the qualifications of any of his assistants open to question. There is nothing in the case or its surroundings to raise the slightest suspicion that Dr. Van Deusen or his assistants, upon whom the care and treatment of Mrs. Newcomer devolved during the time she remained in the asylum, were or could have been influenced by any improper motives in secluding or keeping her within the institution.

This protracted and careful trial has developed no new evidence against the defendant upon the question which divided the Supreme Court, and hence the fact must be held now as decided by them, upon the testimony produced on the former trial, viz.: that Dr. Van Deusen and his assistants believed the plaintiff insane when she was in the asylum, and that there is nothing legally tending to show that he did not act in good faith, and as became his office, in receiving her for treatment

assistant medical superintendent for the asylum; two assistant physicians and matron. It has about one hundred and fifty attendants and assistants and over four hundred and fifty patients. The various departments are under the immediate charge of supervisors, who see to the administration of medicines, and communicate with the physicians respecting the wants and condition of the patients. The matron has the general charge of the female inmates. Besides these it has various other officers connected with it, such as treasurer, steward and the like. The duties of the medical superintendent are quite extensive. He has the general charge of the buildings, grounds and farm, together with the furniture, fixtures and stock of the institution. He is the business manager of the entire concern and its chief executive officer, overseeing everything connected with the establishment, including the keeping of its accounts. Of necessity a very large portion of his time and attention must be devoted to other matters than the immediate care of patients, this work being entrusted largely to assistants. All admit that these officers are not, in any legal sense, his agents or servants, and that he is in no way responsible for their acts, except so far as he participates in them by directing them to be done. At the threshold of the case arises a question as to the extent of his responsibility for the seclusion of Mrs. Newcomer in the asylum, admitting him to be liable at all. The defendant received, examined and admitted her into the building, but that is all he did. He had no more to do about the immediate care, custody or treatment of her afterwards than with the acts of the engineer in heating the building. Much of the time she was there he was absent, attending to duties elsewhere, and some of the time not even in the State. Can it be said that the one act he did would necessarily, or even probably result in the plaintiff's being detained until August, 1875? The statute requires the patient's condition, as to sanity, to be ascertained daily, so that his determination, the first day, upon that fact, only determines what her treatment shall be until she should be again examined. Was not her detention after the

first day, in consequence of conclusions as to her mental condition arrived at by other officers appointed by law for that purpose, and with which he actually had nothing to do, since, if these officers concluded she was sane, either the second, or upon any subsequent day, she would then have been discharged? If Dr. Van Deusen be only liable for his own acts could he be held liable after that one act had spent its force, which it did the first day? Was not her detention afterwards the result of other agencies in which he took no part? Would he be more responsible for this part of her treatment, by his assistants, than for the result of medicines they might have prescribed, or other acts of theirs in regard to her, and with which it is admitted he can not be charged unless he took part in them?

The main question in the case, however, is deeper than this. All the damages which are claimed by Mrs. Newcomer, arose from acts which were done by the defendant, as medical superintendent of the asylum, and while acting officially as such within the line or limit of his duty, or by officers acting under him, as provided by the laws of the State. His skill as a physician, and experience in the treatment of the insane, appear in the proofs, and are denied by none, nor are the qualifications of any of his assistants open to question. There is nothing in the case or its surroundings to raise the slightest suspicion that Dr. Van Deusen or his assistants, upon whom the care and treatment of Mrs. Newcomer devolved during the time she remained in the asylum, were or could have been influenced by any improper motives in secluding or keeping her within the institution.

This protracted and careful trial has developed no new evidence against the defendant upon the question which divided the Supreme Court, and hence the fact must be held now as decided by them, upon the testimony produced on the former trial, viz.: that Dr. Van Deusen and his assistants believed the plaintiff insane when she was in the asylum, and that there is nothing legally tending to show that he did not act in good faith, and as became his office, in receiving her for treatment

within the institution. Upon this fact arises the legal question which vexed the Supreme Court, and which is stated in one of the opinions rendered, as follows: "Where a person is brought to the asylum by or at the request of his relatives, would the superintendent, who after a careful investigation and examination of the patient, in good faith, and a belief based thereon, that he was in fact insane, act at his peril in receiving, detaining and treating him thereafter?" The plaintiff claims she was not insane when taken there, and insists that this fact, (upon which it may be said there is evidence both ways), should be left to the jury, and that the belief and good faith of the defendant constitute no defense to the action. If, however, the question of law left unanswered by the Supreme Court, should be determined against her, there is nothing for the jury to pass upon. This question must settle the case.

Little need or can be added to the elaborate reasoning of the two judges who hold that this would be a defense to the action, but some of the opposing positions deserve notice.

The opposing opinion states: "But I think he (the medical superintendent) is to be classed with the public officers of the State, and is entitled to all the advantages and protections which the law accords to officers performing analogous duties. The legal protection which the law accords to officers must depend very largely upon the nature of their duties, whether they are ministerial merely, or are discretionary or judicial. If they are ministerial, the officer has a line of duty clearly marked out for him and he must follow it at his peril; if they are judicial in the full sense, the very nature of the authority is inconsistent with civil responsibility for mistakes in judgment. There are, however, a class of duties which in a qualified sense are judicial, and in another sense are ministerial, where the officer is required to do certain acts, with limited powers to pass his own judgment upon the rights of others. In such cases, the officer has been held exempt from responsibility where he has acted in good faith, however great his error, but liable where another has suffered from his ignorance or malice."

The law, thus fully and well stated, is sufficient to enable us to find the true rule in this case. Looking now at the statute and all the opinions, we find three admitted cases or classes of persons, (aside from those imprisoned), who are entitled to the benefits of, and may be sent to the asylum. First, the pauper insane who are sent by the superintendents of the poor or supervisors of towns; second, the indigent insane not paupers, who are sent by the probate judge, after an examination with or without a jury, in his discretion; and third, those who are sent to the asylum by their friends, who pay their bills. The case under consideration comes within the third class, but the duty of the medical superintendent, from which alone springs his liability, is the same towards the patients in each class so far as it can be found written in the law. His responsibility can not be different when dealing with one class than with the other unless the duties required of him are different. Where the pauper insane were sent no kind of a judicial investigation in advance as to their sanity was had in 1874, and where the indigent insane were sent by the judge of probate, but a partial inquiry was made, the investigation being almost wholly directed to the indigence of the patient. But when received at the asylum, these were treated precisely the same as when sent by their friends. All admit that a time may come when patients of either of the three classes are entitled to their discharge, and this is arrived at in the same way and depends upon the same circumstances in each class. In determining when this time has arrived, the superintendent acts judicially. The proposition is stated in the opinion referred to as follows: "There are cases in which the powers which the superintendent necessarily exercises seem to be judicial. I allude particularly to the case of patients received when insane, and improved and supposed to be cured by the treatment they have received. The time comes when such persons are entitled to their discharge, but exactly when it has arrived, the superintendent must in the first instance decide. Should he maliciously continue the confinement after a

cure had been effected, he could rightfully be held responsible; but if through error of judgment, he failed to discharge the patient, he might with great justice claim the benefit of the rule which under corresponding circumstances protects officers who exercise authority of a *quasi* judicial nature. But under such circumstances the superintendent is dealing with a case in which insanity having unquestionably existed, a presumption of its continued existence favors his action."

This would seem to concede the whole controversy, and establish the position claimed by the defendant, for if the superintendent is to decide how long the patient is to be detained, it necessarily follows that he is to determine whether he is to be detained at all or not. If he is to decide whether the patient is to be kept a year, a month, or a week, he must also of necessity determine whether he is to be detained an hour or a moment, for these are included in the weeks and years. If the superintendent decides the patient sane when presented, he must then and there instantly discharge him, because that conclusion determines and settles how long a time he can detain him. The presumption of a continuance of the insanity for which he was sent there, is but evidence of the fact to be determined, and upon which it is claimed his responsibility depends, and not the fact itself. The patient may have been insane when the officers or the judge of probate acted upon the matter, but entirely sane upon reaching the asylum. The determination of the superintendent is, however, always open to review upon a proper proceeding, instituted in a court for that purpose.

Among the objections urged against allowing the superintendent to pass upon the question of the patient's insanity when sent by his friends, are the absence of notice and opportunity given him or his friends to produce evidence to show that he is not insane, and the lack of publicity attending the proceedings; yet the proceedings of the probate judge, as well as of the other officers referred to, and upon whose certificate it is said the superintendent may rely for his protection when sent by them, are open to the same objections in

a still greater degree. In the case of the indigent insane who are not paupers, the procedure has little of the semblance of legal investigations in courts. The application may be made on behalf of the person alleged to be insane, by a stranger. No citation or notice of any kind is provided for, whereby he or his friends can be advised of the matter. No provision is made for any kind of hearing in their behalf, by counsel or witnesses, but the probate judge himself calls "two respectable physicians and other credible witnesses," and with the assistance of the prosecuting attorney, conducts the entire investigation. There is nothing in the law requiring the insane person even to be present, nor does it contain a provision whereby his presence can be secured; and from the fact not only that no notice is given him, but that the physicians simply file sworn certificates, it would seem that he was not by counsel or friend expected to cross-examine these witnesses, for if they were to be examined orally, certificates would not answer the purpose. When the investigation is closed, and the probate judge deems the person indigent and also insane, he still has no control over his person. He does not direct him to be sent to the asylum, nor can he issue any writ or process upon which an officer can take him there. That duty is still left for his friends to do. The expressed provisions of this law may all be complied with, and neither the person most affected by them or his friends know anything about the matter, while as the law was when Mrs. Newcomer was in the asylum, the pauper insane were sent upon the mere order of the superintendents of the poor or of the supervisor. No notice was required, and no pretense of an investigation was had, and the whole business might have been done in a closed room, the officers acting having no qualifications fitting them for the delicate duties assigned them.

If weighed upon their merits, no one will claim but that an examination by the medical superintendent of the asylum, skilled as he is, and must be in the treatment of the insane, and his conclusion therefrom, is entitled to much the greater consideration. Indeed,

without the aid of an artificial presumption, the proceedings of the judge of probate and the other officers mentioned, would be of little if any weight as evidence of the patient's actual mental condition.

As a rule, courts can not write a record that will bind an insane person at all. It is only when a man is sane that it can enter a judgment that he is insane, which will establish the fact against him conclusively. Proceedings in regard to this class can not be conducted as in other cases where wrongs are righted or punished. They are necessarily out of the usual course of things. The emergency is too urgent, the necessity for action too immediate and pressing to admit of notice being given, and the delays consequent upon judicial proceedings. If the patient is to be treated at all successfully, it must be done promptly; the earlier the better. The progress of the disease can not be stayed by an order of court to await its conclusion as to whether he is mentally disordered. Nor can a court weigh the best evidence of the fact sought to be proven, viz: the person himself. It can take the opinions of others about him and weigh those opinions, but the verification of the fact under investigation, although before its bar, it can neither understand nor judge of. The matter to be determined is not a legal, but a medical question. It is not whether the person is a law breaker, but whether he is a fit patient to be treated in the asylum. It is admitted that the asylum is not in any sense a prison or bedlam, but a retreat for proper instruction and treatment, and if a court can in advance determine whether this part of the treatment is proper, it can as well prescribe whether and what other treatment is necessary, and the medicines the patient shall be given while there.

But however desirable an inquisition in a court upon this point might be, it is sufficient to say there is no way or method known whereby this can be had in cases like the present one. When it is said that where a patient is presented by his friends for treatment at the asylum, and his sanity "is open to possible question, prudence should dictate a judicial investigation," the fact that no such investigation is possible seems to

have been overlooked. Our laws have made no provision for action by any public officer or court, in cases of this kind and class, and to require the superintendent to take such a step, and have an inquisition in advance to determine the sanity or insanity of the patient before receiving him into the asylum, is to require of him an impossibility, and if this direction were followed it would close the doors of that institution to the applicant forever.

Another reason urged against leaving the decision of the patient's sanity to physicians, while admitting the high character and learning of a large proportion of them, is stated as follows: "We can not for a moment shut out from view the fact that the law throws wide open the doors of that profession, and that the ignorant jostle the learned in entering it, the unworthy have equal rights with the high-minded and humane, and it is not uncommon that the most unfit succeed for a long period in imposing upon the public. By no means known to the existing laws can it be rendered reasonably certain that, in the absence of public investigation, questions of insanity will be considered by competent persons, and mistakes guarded against by those who are fit to judge." But if this test were applied to the magistrates in the State, it would empty many of their chairs. We confide to them, however, the protection and disposition of our property, our liberty, and even our lives, but they are not always fit to judge upon the matters they are authorized to decide. No qualification or knowledge of the duties they are to perform is made a pre-requisite, or deemed necessary to fit them for the places they hold. No magistrate need know anything of the law he is to administer. There is no statute requiring the judge of any court in this State to be a lawyer. Even as to judges of the supreme court no such test exists. The law throws wide open its doors to all aspirants for judicial positions—the way is free for all—and thus far the State has suffered no injury therefrom, while the individual rights of the citizen have, as a rule, been entirely secure and safe under the administration of officers so elected. Experience, there-

fore, does not teach us that the danger from this source is so great as to cause serious apprehension, while the statute itself fully answers the entire argument based upon this supposed danger by providing that the medical superintendent of the asylum "shall be *a well educated physician, experienced in the treatment of the insane.*" The door is thus completely closed to that class of medical pretenders from whom this apprehension of danger arises. The law requires a higher and more severe standard of ability and fitness for the place in this than in any other State office.

But it is said that where a sane person is confined, by reason of an error in judgment of the superintendent, "it can not be that no one is responsible. The law of no free country can tolerate a condition of things under which a person innocent of crime, and threatening no injury to himself or others, can be restrained of his liberty, and no person be responsible for the injury he suffers." Yet it is certainly true that such things do exist, where no one is responsible for the injury sustained. It is a matter of common knowledge that persons are sent to jails and prisons, and confined there for months and years, who are innocent of wrong, actual or threatened. Sometimes this is done through the ignorance of magistrates or of juries, but very rarely through their wantonness or malice. Behind the doors of our prisons to-day languish men innocent of crime, whom no human power can liberate until the term of their unjust imprisonment has expired. The law holds them in its inexorable grasp, and will not listen to the proofs of their innocence. A false record declares them guilty, and this is conclusive upon them, but those who wrote the falsehood are not, nor is anyone responsible for the injury sustained, so long as they acted in good faith.

These things, however, are a necessary incident to the administration of the laws, and will continue to be so long as they are administered by mere men. However pure and perfect our magistrates are; however high and learned our judges may be, the best of them will at times err, and thereby commit great wrongs to

individuals. It requires no very vivid imagination to people the halls of justice with victims whom the law, thus administered in exceptional cases, has crushed and ruined.

The fact is, all power is dangerous, and were we to take counsel of our fears alone, none would ever be exercised which, by any possibility, could interfere with our liberty or property. But the safety of the State, the peace of communities, the welfare of society, and the protection of private rights demand that these risks be taken. Without its exercise society, in an organized form, can not exist. When, under what circumstances, and to what extent it shall be used, must be left, in a measure, to the erring judgment of the officers who are to administer it. Under the laws of this State, the power and duty to restrain and care for the insane is conferred upon the medical superintendent of the asylum, and in its performance he can not be held to a higher or different degree of responsibility than other officers exercising like powers. Nearly, if not all, the reasons urged against this position apply with equal, and some with added force to the other officers designated by the law to perform similar or analogous duties over other classes of citizens.

It is said, however, that the laws have given to the asylum authorities no jurisdiction over sane persons. Almost in the same sense it might be said that criminal courts have no jurisdiction over persons who are not criminals, but they assume it, and with impunity condemn and imprison innocent people. It is also admitted that where a sane person is sent to the asylum by the judge of probate, the superintendent may receive and detain him without subjecting himself to an action for damages; and it will not be claimed that the probate judge, in arriving at this erroneous conclusion, although in one sense it cost the person his liberty, rendered himself liable to an action for the injury inflicted. His judicial mantle protects him. Where the medical superintendent of the asylum, under the command of the law, performs these duties, he may justly ask that the courts hold the same shield over him, for courts

may not extend immunity to members of their own tribunals, which they deny to other officers acting under the same circumstances. Like reason makes like law.

It is evident that somewhere must exist the power and duty to determine whether a particular individual comes within the class designated by law as insane. Such a tribunal is a necessity, if the provision of our constitution, in regard to asylums for them, is to be carried out. Investigations of this kind are necessarily *ex parte*, so far as concerns the person claimed to be a lunatic is concerned. The law has always regarded these as proceedings *in rem*, whereof notice could not be given as in common law actions. However much deference is to be paid to the determination of the judge of probate, when the investigation is before him, although *ex parte*, or to the deliberations of the fireside forum, these are inadequate to meet the necessities of the case. They may perhaps be sufficient to raise a presumption that there was probable cause to believe the person at that time insane, and be allowed to occupy a place similar to preliminary examinations by magistrates in criminal cases, but there should still be, in addition, some competent and skilled officer to examine the case anew. The intellect is a matter of too much importance to be left a day dependent upon a bare legal presumption. The hope and possibility of a change for the better in the sufferer is sufficient for humanity to imperatively demand that the patient be made the subject of constant and daily tests. The statute attempts to provide such an officer with duties and powers very clearly defined. Thus: Section 1,914, of the compiled Laws, requires the trustees of the asylum to appoint a medical superintendent, "who shall be a well-educated physician, experienced in the treatment of the insane." What for? and why is he required to possess these high qualifications, if he is not to use them?

When is he required to exercise them? Section 1,920 answers this question in the following emphatic language: "He shall daily ascertain the condition of all the patients." That does not mean the second, or any subsequent day after the patient's arrival merely,

but it means the first day also. It means every day, including the first, he is at the asylum, without regard to the class he belongs to, or any presumption as to his condition when he started for the institution. The fact that he is to make these daily tests, recognizes the law of change rather than the presumption of a continuance of his disorder, and implies that humanity and the laws of health, rather than a dry legal rule shall govern his conduct towards the patient. And that the officers may always be at hand to perform this duty upon the patient's arrival, sec. 1,914, as amended in 1873, requires the medical and assistant medical superintendents to "*constantly reside in the asylum.*" This daily duty is to be peformed until the patient is restored to soundness of mind.

The law then commands the superintendent to at once pass upon the patient's condition, on his arrival at the asylum, whether sent by his friends, the probate judge, or otherwise, as well as daily thereafter, so long as he remains in the institution. This ought to settle the question in dispute, for all appear to concede that if this be a duty enjoined upon the medical superintendent by law, he can not be held liable for a mere error in judgment in performing it. Indeed, the bare fact that the superintendent is to treat the person, and that he is brought there solely for treatment, and to the end that he may be healed, necessarily implies that this officer must exercise his judgment, and determine what is the matter with him, for otherwise how can he know what to do with the patient? If he finds him insane, that determination makes it his duty to receive him into the asylum, the detention there being only a part of his treatment. If he decides this at his peril, then he is equally as liable for refusing admission to an insane patient as for receiving one who is sane. No law ever applied such a superhuman standard of ability to an officer as this proposition implies.

The statute requires the superintendent to be a well-educated physician, experienced in the treatment of the insane, and it never contemplated he should exercise a degree of skill or knowledge which it did not require

him to possess, and especially to which no human being ever yet attained. The law does not demand impossibilities of men. Adopt the rule contended for, and make him responsible for errors in judgment, and the officer must be infallible to be safe. Nor would even this be sufficient for his protection, if the matter is to be afterwards overhauled in an action against him for damages, unless the trial jury and judge are also infallible, for they, with their imperfect understandings, may decide that which was infallibly right to be wrong. That a sane person, by an error in judgment of the medical superintendent, may be confined in the asylum, is perhaps within the range of possibilities, but when the fact that it contains so many officers, assistants and attendants, with more or less of whom the patient comes in daily contact, and the daily test he is subjected to, are considered, the possibility of such an occurrence becomes too remote and shadowy to be made the basis of a rule of law, except upon the theory that these officers, assistants and attendants are conspirators, banded together for the purpose of shutting up within the asylum cells, secretly, and beyond the reach of friends, all people whom they can get hold of, merely to gratify a cruel and wicked disposition—that, in short, the institution is a place where those who enter leave hope behind. Unless some such extravagant view as this be taken of the situation, it is incredible that a sane person need remain there any particular length of time against his will. But courts have no more right to assume that the officers of the asylum will act in bad faith than will the judges of courts. Whenever such a case arises it will be time enough to deal with it. No rule of responsibility can be founded upon such a theory. Perfection does not exist, however, in any system ever yet invented by man, and hence it is only reasonable to presume that the one adopted for the government of the asylum has its defects, which those who make its laws will remedy as time and experience demonstrate them. The lack of sufficient publicity attending the admission of patients into it, is the one entitled to the most consideration;

but, as it now is, so long as the medical superintendent or his assistants, and the assistant physicians, faithfully and honestly perform the daily duties imposed upon them by law, in regard to the examination of the patients, and are competent to fill these positions, the danger from this direction bears no comparison to the risks incident to proceedings in legal tribunals.

But the probability of injustice being done to the superintendent, if he is to be held answerable to every adventurer who chooses to sue him after leaving the asylum, are incomparably greater than of wrong to sane persons by being confined within it. A jury is not so competent to ascertain whether or not the person was insane when in the asylum, as the officers of the asylum who base their opinions upon examinations made at the very time when the person is afflicted with his malady, and hence upon evidence that can not lie or be distorted, or in any way depend upon the fading or prejudiced opinion of witnesses, unless their learning, skill and experience in the detection of mental disorders, and their opportunities to determine the fact, are matters of no account. No one experienced in the trial of cases in courts will, for a moment, doubt this, so long as all parties act in good faith. To subject their carefully considered and intelligent conclusion to the test of a trial before a jury, months or years afterwards, is, in point of ability, appealing from a superior to an inferior tribunal, which, in many instances, would result in wrong to the superintendent. If greater publicity should be given the proceedings, in regard to the admission or examination of persons in the asylum, let this be provided for by those who have authority to make laws for that purpose, instead of visiting upon the officers of that institution the possible consequences of such omission in a supposed case. In the case at bar the plaintiff does not claim she suffered injury from any such source. It is not pretended but that her relatives had full notice and knowledge of the proceedings, and of the facts as to her situation. All concur in saying that she was taken to the asylum in one of the methods provided by law for that purpose,

her relatives consenting, and that is sufficient for the purposes of this suit, even if the law allowing her to be sent there might be bettered. Indeed, it is almost impossible to conceive how greater notice could have been given.

The question, then, may be reduced to this:

1. When a person is taken to the asylum by his relatives, he must be received or rejected by the medical superintendent, without the judgment, aid or direction of any other officer, court or judge, the law providing no way by which their judgment, direction or aid can be invoked, either by the alleged insane person, or by his relatives or friends, or by the superintendent.

2. The superintendent is thus forced and compelled by the high mandate of the law to decide what is to be done in the premises, according to his own judgment, without assistance outside the asylum, but he is not required to decide according to the judgment of anyone else.

3. The law can not be guilty of such a monstrous wrong as to command him to decide and determine the patient's condition according to his own unaided judgment, and then punish him for obeying its requirements.

There is nothing in this case tending to show that Dr. Van Deusen has violated any law of this State, in his treatment of the plaintiff, and if he is to be held responsible for anything it is for observing the law, and performing a duty which it enjoined upon him. An action based upon a liability springing from such a source is not entitled to favor in a court of justice.

The superintendent of the asylum has jurisdiction over the subject matter of insanity, and, under the statute and laws of the State, authority and power to decide *prima facie* what persons come within that class when presented to him for that purpose, in either of the methods provided by law, and when so called upon, it is his duty to decide the fact, and this determination will protect him while acting under it, until reversed by a proper tribunal. In exercising this

power he performs a duty of a *quasi* judicial nature, and is entitled to the same protection as other officers exercising like powers. Like them in its performance he must be left free to act upon his own unbiased convictions, uninfluenced by fear of consequences. He is not bound at the peril of an action for damages to decide right, but to decide according to his own convictions of right. Such of necessity is the nature of the trust assumed by all on whom power, in its nature judicial in a greater or less measure, is conferred. This trust is fulfilled when he intelligently and honestly decides according to the conclusion of his own mind, in a given case, although there may be doubts of its correctness, and when another mind might honestly come to a different conclusion. If he decides the question of whether the person presented is a fit patient for treatment in the asylum, at his peril, no one, with sense enough to perform its duties, could be found to accept the dangerous position of medical superintendent of the asylum for the insane. If this be the measure of his responsibility, the walls of the institution may as well be razed to the ground, for the days of its usefulness are over, at least so far as private patients are concerned. Such a rule would defeat the object and purpose of the law in founding it, and turn this great charity of the State into an engine of wrong, working ruin to those honestly and faithfully endeavoring to carry out the State's benevolence.

The rule of responsibility applied to other officers performing duties thrown upon them by law, and whereof the necessity for their action is confided to their discretion and judgment, must govern this case. The jury will therefore be directed to render a verdict for the defendant.

JOHN B. SHIPMAN, *Circuit Judge.*

After the delivery of the opinion and charge the jury returned a verdict for defendant, in accordance with the instructions of the court.

Since the foregoing was put in type we have another decision, rendered by the same judge, upon a motion for a new trial, made by the plaintiff in this cause, on three distinct grounds, which are recited and reviewed by the judge in detail. It will be sufficient to indicate the points, without copying the opinion in full.

The first ground was the omission of the plaintiff to use in her *direct* evidence the clinical records or notes made in the institution, as a daily history of the patients, having reserved them for rebutting testimony. In this way, however, they *were* used on the trial to show discrepancies in the testimony for the defense, but with little or no effect. The judge decides these records were used for all they could show, and that no testimony offered, bearing on the question of good faith, had been ruled out.

The second ground, (and a more plausible one), was, that the question of "good faith," as a *matter of fact*, should have gone to the jury. The plaintiff's counsel, in the previous proceedings, had, on occasions, both admitted and denied the fact of good faith, but claimed it was no defense. He now claims that the court should have defined what constitutes good faith, and then left it to the jury to say whether it existed.

In answer to all this, Judge Shipman reiterates the principle that it is the right of the court to decide whether or not there is any evidence tending to show bad faith in the defendant receiving a patient into the asylum, and if he finds there is *not* any such evidence, to withdraw the question from the jury. He cites a large number of cases, from both the State and national courts. In 40 Mich., 150, the court says, "where there is only a *scintilla* of evidence on any essential fact, the case should be taken from the jury." In 54 N. Y., 360, (*Alger vs. Gardner*), the court declares, "it is error for

a judge to submit a question to a jury where there is no evidence to authorize any finding thereon, and it is for a similar reason correct to refuse to submit a question unsupported by evidence." In 94 U. S., 284, (*Commiss vs. Clark*), the Supreme Court lays down the rule that, "before the evidence is left to the jury, there is, or may be, in every case, a *preliminary* case for the judge, not whether there is literally *no* evidence, but whether there is any upon which a jury can properly proceed to find a verdict for the party producing it, upon whom the burden of proof is imposed;" and again, in 22 Wall, 122, the true principle was said to be, "if the court is satisfied that, conceding all the inferences which the jury could justifiably draw from the testimony, the evidence is *insufficient* to warrant a verdict for the plaintiff, the judge should *say* so to the jury." He also cites the recent case of Dr. Hitchcock, who was sued by one Burgett for negligence and want of skill in treating him for an injury to his hip. The presiding judge allowed the case to go to the jury, who rendered a verdict for the plaintiff on what was claimed to be the evidence, but the Supreme Court held, on review of the case, that there was no evidence in it, under which the doctor could be held liable, and that the judge should have so charged, or taken it from the jury.

In this case before us, Judge Shipman goes on to say the strict issue presented is, whether the defendant committed a trespass to the person of the plaintiff, and falsely imprisoned her; not an action for malpractice or negligence or ignorance. In cases of trespass for false imprisonment, the question is whether the magistrate had jurisdiction to issue the process: here the question is, did the medical superintendent have juris-

diction of the subject matter and did he act in good faith? If so, trespass would not lie even for subsequent careless or negligent treatment. Still the plaintiff was allowed to show everything, but the evidence submitted hardly amounted to more than a *scintilla*, to prove either bad faith or bad treatment.

The opinion also goes pretty fully into the subject of the competency of witnesses, especially those who have been insane. This part of it would be of considerable interest to the specialty, aside from the particular issues of this trial; but our space is already too much occupied to reproduce it here. We simply give the rule on this point, quoted from Wharton: "If the witness appears on examination by the judge, or by evidence *aliunde* to have been incapable *at the time of the occurrence* which he is called to relate, of perceiving, or to be at the time of the trial incapable of relating, then he is to be ruled out." On this rule, it is not difficult to see how little importance could be attached to the evidence of a person who had undoubtedly been insane, like Mrs. Newcomer, as to any events or circumstances occurring during that period.

The *third* ground for the motion simply raised the question whether "good faith" is a defense, viewed as a matter of law. This point was sufficiently gone over in the previous decisions. The objection is now made that if a superintendent acts judicially in receiving a patient and judging of his insanity, he could not be afterward liberated on a writ of *habeas corpus*. The judge meets this by saying that it is *not* the superintendent who places or consigns the patient to an asylum. His act is but the diagnosis of a physician employed by the State, to treat patients *sent* to the insane hospital. A private physician can choose his patients; a superintendent is compelled by law to act for all who

are sent him; "but he is in no sense a prison warden, and can not be held liable as such."

We suppose this means that a superintendent acts judicially only *pro hâc vice*, to determine the question of insanity, whether it confirms or reverses the act of those who seek to have the patient committed to the asylum in accordance with law, unless, indeed, the commitment be by order of a court, in which case there may be no immediate discretion.

We think all our readers will agree as to the great interest of the questions handled in this case, and acquiesce in the propriety of devoting so much space to it in this JOURNAL.

# ENGLISH LUNACY LAWS.

1. *The Evidence before the Select Committee of the House of Commons on the Lunacy Laws:* 1877.

2. *The Journal of Mental Science for January*, 1878. London: J. & A. Churchill.

3. *Lunacy in its Relations to the State.* By Sir James Coxe, M. D., F. R. S. E., F. R. C. P. E., Commissioner in Lunacy, Scotland.

In consequence of certain random statements, bruited about in the public press, and emanating, as is supposed, chiefly from a few partially recovered lunatics, who were at large, the House of Commons appointed a committee, early in the last year, of fifteen members, with Mr. Stephen Cave as chairman, to investigate the efficiency of the lunacy acts, as bearing upon the liberty of the subject, and the possibility of sane people being incarcerated under these acts, by mistake, fraud or conspiracy. The inquiry, however, took a much wider range, and extended to the whole subject of the general treatment of the insane, from the manner in which their insanity is first determined, to the final question of recovery and restoration to liberty; the two points about which, as the most important, such an investigation must chiefly concern itself. When once the inquiry was gone into, it became of little consequence what circumstances may have caused it to be instituted, though there does not appear to have been any *cause célèbre*, or any special public event, to draw attention to the subject. At any rate, we look in vain through the huge Parliamentary Blue Book, of 582 pages, with 11,462 questions and answers, which was the outcome of this commission, for the testimony of any recovered

lunatic, as to his experience of lunatic asylums. Of the fifty-nine witnesses who were examined, seventeen were government officials, and of the twenty-six medical witnesses only *three* were taken from the ranks of general practitioners, (the class who usually sign the medical certificates), and of these three only one was questioned beyond certain points connected with individuals. Only one member of the numerous committees of visitors of the asylums, not a single visitor of the provincial licensed houses, and not a single member of the legal profession was examined; while the poor law guardians in England, and the sheriffs in Scotland, and the inspectors in Ireland, (except one Dr. Nugent), all of whom have so much to do with carrying out the lunacy laws, were completely ignored. Surely the *insouciance* of red tape could hardly be carried further.

Of course, the testimony on the general subject of insanity, given by such witnesses as Dr. Bucknill, Lord Shaftesbury, Dr. Robertson, Dr. Maudsley, Sir James Coxe and Dr. Nugent, could not but present many valuable opinions and results of experience, on a great variety of questions; but our object is, if possible, to sift out the actual truth in regard to the bearing of the lunacy laws, in their practical operation, upon the personal liberty of the citizen or subject.

It is as good as an axiom of civilization that it is the duty of the State to protect the community from any risk that might arise from the actions of an insane man; we may add, to protect the insane person himself from damage in person or property from his insanity. Hence, the initial question of all is, what constitutes insanity, and how is it to be determined? This, and nothing less, is the issue presented by the old common law writ, *de Lunatico Inquirendo*, as applied to any individual subject. This goes directly to the

question of every man's personal liberty. The lunacy laws of Great Britain provide that any person, to be brought within their provisions, must be certified, on *medical authority*, to be "either a lunatic, or an insane person, or an idiot, or a person of unsound mind." The Statute of New York provides that "the terms 'lunacy,' 'lunatic' and 'insane,' as used in this act, shall include every species of insanity, and extend to every deranged person, and to all (cases of) unsound mind other than idiots," for which last there are separate and special provisions. It is hardly possible for a law to enter into a scientific definition of insanity, or do more than use a succession of terms, which are rather synonyms than definitions of each other. Our statute also requires the fact of insanity to be established in all cases by medical authority, the certificate of two physicians under oath being required, both of whom must be graduates of some incorporated medical college, and of at least three years' standing as practitioners. They can also certify only after actual *personal* examination, and their certificate, as well as their qualifications, must be approved by some judge of a court of record, who has the discretion of instituting proceedings in the nature of the old inquisition of lunacy, in order to verify the facts. Though a matter of actual experience, public officers are too apt to act, in many cases, in a mere ministerial capacity, the intent of the law apparently is to rest the determination chiefly upon the medical authority. And the remarkable fact comes out, all through the testimony before this parliamentary committee, notwithstanding the criticism made by some against leaving such a question to members of the profession at large, instead of to experts, that the medical certificates have very rarely made any mistake. Many of the witnesses never knew of a case in which a sane person had

been dealt with as a lunatic, under the ordinary mode of procedure; and that, too, although it appears, in England, a total "stranger" may sign the "order" for commitment to an asylum after the medical certificate, which "order" does not require to be countersigned by any public authority whatever, and it is not made anyone's duty to inquire or know why such order was signed. It seems incredible that abuses should never occur, under such a state of the law as this. It speaks well for the truth and fidelity to science, which, after all, become habitual to all practitioners who aim at a useful and reputable standing in the community. The New York Statute, it will have been seen, does not leave so much to be taken for granted. If medical collusion, or ignorance even, were suspected, it would be perfectly feasible to right the wrong, even before the patient reaches the asylum, through the inquiry which is left open to the public officer. In Scotland the provision is similar to ours, in that the medical certificates, required for both private and pauper patients, are the same, and the "order" is given by the "sheriff," though the witnesses in this inquiry were not quite clear, as to whether these sheriffs act in a judicial or ministerial capacity. The Scotch law, however, is defective, in allowing a total "stranger," (in the legal sense), to petition the sheriff for an "order," which he may even grant on medical certificates six months old.

In the first instance, then, as a general rule, the "liberty of the subject" depends, *quoad hoc*, the question of insanity, on the correctness and good faith of medical testimony. We do not see how, after all, this can be otherwise. It is no more than saying that the convalescence of the sick man, (if *not* the health of the community), depends on the care and skill of the physician. Insanity, as a *disease*, comes entirely within the

scope of the medical profession, and is exclusively a subject for medical diagnosis and medical treatment. The sooner this is everywhere acknowledged, and acted upon, the better for humanity. As a disease it is often sufficiently subtle, and even obscure, to give rise to differences of opinion. They who have regarded it as a mere state of mind or emotional condition, may well insist upon the chances of mistake. But if insanity is a *disease*, as we know it is, it should be dealt with from first to last on medical principles. Of course, we have no objection to Lord Shaftesbury's argument against "special doctors," that "they would surrender everything to science, and shut up people by the score." Our New York law goes far to exclude specialists, in providing that no certificates shall be given by any officer or professional visitor of an insane institution, for admission to that with which he is himself connected. We prefer, however, the alternative presented by Dr. Crichton Browne, who, in his testimony, earnestly advocated a short course of study of mental disease for *all* medical men. And we may say in passing, that we by no means agree with the strictures of the *Journal of Mental Science* upon Dr. Browne's statement that lunatics are very frequently treated unkindly among their friends, in the early stage of their insanity. No doubt it is true, as Sir James Coxe says, when speaking on the question of medical experts, that a man's own relatives may be the first to perceive a departure from his normal condition; but no degree of ignorance was ever incredible, and there is far more truth than we like to contemplate in Dr. Browne's strong statement that "cruelty and chastisement, as if for an ordinary case of misconduct, are the rule in the early stage of insanity." The remark that "mismanagement from ignorance is common, cruelty rare," seems strangely inconsequential to anyone

who has observed the state and condition in which patients are often brought long distances to an asylum, and has learned to appreciate the fact that there is no cruelty like the cruelty of ignorance. The researches of science, and the humane labors of specialists, have accomplished a vast deal in abolishing or mitigating the rigors that once prevailed both within and outside of institutions for the insane; and in producing a more enlightened public sentiment on the general subject; yet there can be no doubt that very frequently what, to an experienced medical eye, would be symptoms of the incipient disease of insanity, are regarded only as indications of demoralization, and visited with the harshness on the part of friends and the public, due to perverted principles or moral obliquity. We can not, therefore, quite agree with Sir James Coxe, in what he says with regard to the value of medical diagnosis and evidence in all cases:

> The cases in which most difficulty is experienced in determining the existence of insanity, are perhaps those in which there is an eccentricity of thought, or an excess or deficiency of the moral perceptions. For instance, it may be open to discussion, whether a believer in spiritualism is or is not insane; and a like doubt may be experienced where there has been over-indulgence in the use of alcohol or opium, or where there is such an exaggeration of the natural character as to overstep the bounds which, in common opinion, mark the domain of sanity. In cases of this kind, however, it would be difficult to maintain that any special medical training is required to discriminate between sanity and insanity; and, indeed, it would be difficult to show in what respect a medical man is better fitted than a lawyer, or any man of good sense and liberal education, to determine whether a believer in spiritualism is sane or insane. Further, a medical man can scarcely be said to be in a better position than any other educated man to distinguish between vice and insanity, or to decide between punishing for crime or treating for disease.—"*Lunacy, in its Relations to the State.*"

We should rather say that the task of "distinguishing between vice and insanity" was just the case which would specially require the services of an expert, and in which the common sense of the general public would be most likely to be led astray, and furnish too little security for a correct decision. Indeed, Sir James himself admits that persons, undoubtedly insane, often succeed in passing themselves off for sane, in spite of the closest cross questioning, and that even a medical expert may sometimes be puzzled to obtain evidence of delusion, unless he were previously informed in what direction it lay. He says:

> Many of the witnesses examined by the committee dwelt on the difficulty of recognizing the existence of insanity in cases of delusion, and no one can doubt that this is often a difficulty of a very serious kind. Indeed, even an expert would often be puzzled to obtain evidence of a delusion, unless he were previously informed in what direction it lay; and, with such information to guide him, a non-expert would probably prove equally successful. It appears from the evidence that cases are not infrequent in which the medical superintendents fail for days, and sometimes even for weeks, to assure themselves of the existence of insanity, although they have for their guidance the facts embodied in the medical certificates on which the patients were placed under their care. Here, be it observed, we have the most experienced of experts puzzled for a time, and unable to recognize facts which had already been detected and made known to them. When there is no guide to the delusions, their discovery will often prove a matter of exceeding difficulty, even to the most experienced physicians, although, when once hit upon, the evidence of insanity may be simply overwhelming.

These very facts only confirm the truth that insanity is not a subject that can safely be left to the haphazard guesses of a "general public," or to any other authority than a profession that includes and is devoted to the study of all derangements of the human organization, whether called physical or mental. And the allusion of Sir James Coxe to the "different views advocated by

the medical partisans engaged on each side" of some particular case, only establishes the proposition that the question, before whatever judicial tribunal it is brought, must ultimately be decided by the preponderance of medical testimony. Sir James admits that it is impossible to draw a hard and fast line between sanity and insanity, and Dr. Maudsley, in his testimony, compared it to getting the precise boundary between daylight and darkness. If so, much more does it require medical knowledge and skill to make the distinction. And although, as has been said, a man's own family may be the first, in most cases, to detect the aberration of mind and judgment, a trained physician might generally have been able, from physical symptoms, to warn his friends, some time beforehand, of what was coming. It is of no use to attempt, as Sir James Coxe and Lord Shaftesbury do, to put legal or any other kind of professional knowledge in competition with medical diagnosis, in determining the question of insanity in any individual case. Insanity is a disease, and the fact that its relations and causation are of a subtle or obscure character, only strengthens, instead of weakens, the argument for the exclusive claim of medical science to deal with it. The whole question of its bearing upon personal liberty resolves itself into the simple truism that when a man becomes sick and helpless, disabled from taking care of himself, it is no time to talk of the liberty or labors of life—he must be sequestered, and taken care of. It is but the inevitable of the loss of his health. It is, of course, important that the necessity be fairly and certainly established; but if medical authority be insufficient for this, there is surely no other that can take its place; and men daily commit, not merely their liberty, but their lives to medical skill. As to the practical protection of the medical

certificates alone, we endorse the clear statement of Dr. Crichton Browne:

*Q.* According to the present practice, whenever medical men certify a person to be insane, they have to give their reasons for coming to that conclusion? *A.* Yes.

*Q.* Are you in the habit of seeing the reasons that are given by medical men; does that come within your department? *A.* When I was at the head of a county asylum I had to examine those reasons to see that they were, in my opinion, sufficient.

*Q.* In your judgment, does that afford a considerable protection against persons being improperly confined? *A.* A great protection.

*Q.* The reasons are given to an extent which enables you to judge whether the conclusion as to lunacy has been founded upon sufficient data? *A.* Undoubtedly; and if they were not sufficient I should decline to receive the patient. In signing certificates, medical men are actuated by entirely different notions from those that are sometimes advanced by lunacy practitioners giving evidence in a court of justice; I should never have received in a certificate such a statement as "an irresistible impulse," or "no adequate knowledge of consequences," or vague statements of that kind. The evidence given in certificates is generally substantial, and so clear and free from technicality, that it would be intelligible by any layman.

*Q.* That is your experience of the nature of the evidence set forth by the medical men?. *A.* That is so, having examined some 5,000 certificates.

There can not, however, be any objection to the strictest care and supervision on the part of the State, in regard both to the commitment and the subsequent detention of the insane. The principle of official accountability and oversight should run through this, as well as all other departments of public administration. In this respect the testimony before us shows some obvious defects in English legislation. In the first place, as appears by Dr. Bucknill's testimony, (*Q.* 1,750, 1,755), that any stranger, who can get two medical certificates, may sign an order for the detention of

a wife, (for instance), contrary to the wish of her husband, in any private asylum with which he may make an agreement. Dr. Bucknill condemns this as a state of things which ought not to exist, although he believes persons are "very rarely admitted wrongfully" under it. And yet he declares that some persons are *detained* too long in such asylums. Again, there are two boards of visitors and commissioners, one consisting of three members, for patients who are the wards of chancery, having property of £1,000 and upwards, of whom, in 1877, there were but 995, and 319 of them in private dwellings; the other consisting of six members, having the oversight or visitation of 43,828 patients in public asylums, and 458 private patients in ordinary dwellings; while there are 16,038 pauper patients in work-houses, and 6,312 in private dwellings left to the discretion of parochial authorities, without any visitation at all. This shows one law for the rich, and another for the poor. Dr. Bucknill, and most of the other witnesses, with the exception of Dr. Lockhart Robertson, are earnestly in favor of consolidating these two boards of visitors, and extending their visitation to the lunacy wards of the work-houses, as well as to all the public asylums.

Again, in England, no judicial authority appears to be necessary in the commitment of the insane, the parish relieving officer acting with the clergyman or a justice in all *pauper* cases, with *one* medical certificate; while in the case of private patients, the order, (signed by anyone), with two medical certificates, is sufficient. In Scotland the sheriff must give the order in *all* cases, with *two* certificates; though, in urgent cases, a patient may be admitted on *one* medical "certificate of emergency," which is in force only for three days, long enough for the sheriff to be reached and to pass upon the case.

Obviously, the distinction made in England between pauper cases and others, is both invidious and useless. No valid statistics can be based upon it, with reference to the connection of insanity with pauperism, for in every State a large share of the patients supported by the State, and thus classed as paupers, do not come from the ranks of pauperism at all; for they consist largely of working men, including even professional men, who were amply able to support themselves and their families while in health, the loss of which only deprived both of the means of support.

One characteristic of an ancient civilization, like that of England, is that several interests or institutions that might properly be combined under one head, often grow up separately, though side by side, involving what are called "vested interests," and thus presenting great obstacles to reform by consolidation, codification, or other methods of economizing time and material. The whole system of chancery supervision, with its cumbrous machinery, is a palmary instance of this immobility in the midst of an age of improvement.

In Scotland there is a provision which seems to operate well, by which the asylum superintendent may be required to transmit to the commissioners of lunacy a statement of the "physical condition" of the patient immediately on his admission. The case books of our institutions, always accessible to proper officers, of course exhibit a full account of the condition of patients on admission, as well as the nature of the papers under which they were committed.

But, after all that has been said and done in regard to precautions against fraud or mistake in the commitment of patients, there is, on the other hand, danger of a great evil arising from too great stringency in the requirements of evidence, or too great elaboration in

the details of procedure. That evil is, disastrous delay in getting the patient under treatment, at a time when treatment is of the greatest importance. Both Dr. Bucknill and Dr. Maudsley, in their testimony, bore witness to the principle of early treatment, so generally accepted among the specialty, and the latter showed that medical men, so far from being in too great haste to certify to the disease of insanity in any given case, are, on the contrary, often exposed to many influences which tend to make them postpone such action longer than they really should if they had sole regard to the welfare of the patient himself. Dr. Maudsley's testimony was so suggestive upon this, as well as several other matters, all of which have more or less bearing upon the question of commitment, that we reproduce it almost entire:

*Q.* What is your opinion as to the law of admission of patients into private asylums? *A.* My opinion is that with regard to the admission of patients it is sufficiently stringent, and quite as stringent as it can be, consistent with the proper treatment of insanity in its early stages.

*Q.* You mean you think that if there was more care taken, more delay in admitting or consigning patients to asylums, their cure would be more doubtful? *A.* Undoubtedly; there are two great objects to be kept in view in regard to the detention of patients; they are put under care, not only for their own safe custody, because they are dangerous to themselves or others; but another and most important object, if insanity is to be cured, is that they be put under care for treatment, and early, because recoveries are entirely in proportion to the early stage at which treatment is adopted. If regulations are made more stringent than they are now (and indeed the present regulations operate to some extent in that direction) the friends of patients will, instead of sending them from home, as is almost essential in a case of insanity—unlike in this respect other diseases—keep them at home under proper conditions, and so very much injure the chance of recovery.

*Q.* Would that early treatment necessarily involve sending them from home; could not they be treated to a certain extent as

out-patients? *A.* If a patient is sent from the care of his own friends, even if it is to a private house, it is absolutely necessary to go through the same forms as you go through to place him under care in an asylum; and my experience as a physician is that friends shrink very much from doing that. They dislike the supposed publicity of it; they dislike the formally pronouncing him to be a lunatic; and they will not remove him from home in consequence.

*Q.* Are there not cases of incipient lunacy which might be met by medical treatment, as an out-patient would be treated in other diseases? *A.* No doubt in some cases there might be, but the difficulty of the early treatment of lunacy arises very much from this, that a man does not himself recognize that he is becoming insane. Very few insane people do acknowledge that they are insane; it is quite the exception when they do, and in the early stages it is a most uncommon thing for a man to suppose so; he rebels against all kind of treatment then; will not see a doctor; thinks the idea that he is ill perfectly absurd. Just at the moment when it is most important that something should be done, at that time there is the greatest difficulty in doing what is desirable.

*Q.* It would not apply so much to young people, I suppose, whose relations would ordinarily be accustomed to take them to see a doctor? *A.* It would not apply so much to young people. I think it is often quite impossible, however, to treat, say, a young lady of eighteen who begins to exhibit symptoms of incipient insanity, and who undoubtedly will get well if properly treated, satisfactorily at her own home, simply because the home surroundings are exactly the surroundings in which she can not possibly get well. It is absolutely essential to send her from home, from among anxious and agitated friends, if any good is to be done.

*Q.* Then, again, there are dangers of such a person, as the young lady you mentioned, being sent by mistake to an asylum, in which case the symptoms would be very much aggravated, would not they? *A.* I do not think it would be advisable to send her to an asylum, nor would I do so; but I should send her from home to some medical man's house, or to the house of some suitable person. If I have to do that, I have to go through exactly the same forms as I do to send her to an asylum, and there is the greatest unwillingness on the part of friends to do that. All I desire to see done, if feasible, would be to distinguish with regard to the stringency of admission-forms between the early cases of insanity in which it is a question of treatment, and chronic cases

of insanity in which it has become rather a question of safe custody.

*Q.* And yet all over the country, people are exposed to be sent to an asylum upon the certificates of two medical men, who, really, are not qualified to give an opinion? *A.* There is no doubt about that; but I think the way in which that operates mostly is that, feeling themselves not qualified, they shrink very much from giving certificates. There are some medical men who will not give certificates under any circumstances scarcely. The medical man of a family is often unwilling to do so, because, when the patient comes out from under care afterwards, he probably will have some feeling of hostility towards him; and I am sure the medical profession, as a body, would be extremely glad to be released from the necessity of certifying.

*Q.* Do you think any alteration of the law would be advisable, to meet that difficulty? *A.* It depends on what the alteration of the law is. I have considered the matter. If it is considered desirable, as I heard suggested, that the certificates should go before some public official before they were acted upon, it seems to me that no public official would be in a better qualified position to judge of the value of the certificate than the Commissioners, to whom exact copies are sent within twenty-four hours; indeed, not really so much so. If he entered really into the matter in each case, it would be a very anxious responsibility, a formidable matter for him to undertake; and if he did not, it would simply become a mere matter of routine, which, adding to the publicity, and adding to the expense, and adding to the delay of getting a patient under care, would make the early treatment more difficult than it is.

*Q.* Do you think a medical board, under government, one of whom should, within a certain time, certify, would be an advantage? *A.* It would be an advantage if you could be sure of having him the moment you wanted him; but it seems to me that, in a case of insanity, it may be of the most urgent importance, in a violent case, to take instant action. The man is making the house a perfect pandemonium, and nothing can be done. You would have to go to the official, who perhaps would not be able to come for a day or two.

*Q.* You might meet that difficulty by the emergency certificate which they have in Scotland? *A.* That would be a mode of meeting it, undoubtedly. Then you would have to consider how much the public would object to having a public officer intervene

in every case of insanity, when it was merely desirable to remove the patient from home to a private house near perhaps, or at the seaside. They would shrink very much indeed, according to my experience, from having a public officer come in to proclaim, say, a young lady at eighteen, a lunatic, or a wife after childbirth, who is insane, perhaps, for a month or two. To a professional man, such a public thing might be almost ruin.

*Q.* Would there be greater publicity in that way than there would be from the certificate given by a medical man in the neighborhood? *A.* Yes, it would be thought so; because, as a matter of fact, certificates are often given in this way; the medical officer of the family, who is in regular attendance, gives one certificate; he calls in a physician in consultation, who then sees the case separately, afterwards, and gives the second certificate. There is no alarm of the patient; it is merely an ordinary matter of consultation, as it appears to him.

*Q.* Do you think the system of private houses a good one? *A.* I think it is very important in the early treatment of insanity, in some cases, that they should not be sent to asylums, when it is still important that they should be placed under some kind of care.

*Q.* By a private house do you mean a single house, with one attendant? *A.* No; I object entirely to that, under any circumstances. I mean the house of a medical man, or some responsible person, who overlooks the attendant as well as the patient.

It will be seen that, what with the legal requirements already existing to verify the fact of insanity, the reluctance of physicians to incur the odium of certifying, bringing upon themselves, in many cases, the life-long hostility of the patient, and the dread of publicity on the part of relatives and friends, it more often happens, under the present system of things, that fatal delay takes place in cases of the utmost emergency requiring immediate treatment, than that persons are committed about whose insanity there may be reasonable doubts. Indeed, the curious fact comes out, in Dr. Maudsley's testimony, that the percentage of recoveries is much larger in the public asylums than in the private, which he ascribes to the more summary nature

of the proceedings for commitment to the county asylums, enabling cases to be put under treatment at the first of the attack. In addition to this Dr. Maudsley testifies, (3,779), that "in all his experience in county asylums, as superintendent of a middle-class hospital for the insane, or as a proprietor, he had never seen a single undoubted instance of a person of sound mind being shut up as of unsound mind."

It is well known how easily some kinds of insanity can conceal itself from ordinary apprehension, and make what seems a most rational appeal for sympathy from outsiders, ignorant of their real history and condition. So, in cases partially recovered, or sufficiently so to be accorded their liberty, the public is often imposed upon with a plausible narrative of outrage and wrong, based partly upon imagination, and partly upon a wholly perverted misconstruction of the facts and proceedings in the case. Thus it is with several of the instances of grievances brought before this committee. Even the case of Mrs. Petschler, which the testimony of certain lay persons, who depended chiefly on herself for the facts, appeared to make an overwhelming demonstration of malfeasance in office and fraud in procedure, is entirely dissipated by the Medical Superintendent of the Macclesfield Asylum, where Mrs. P. was a patient, who shows that her papers were in due form, that she was really insane, and had delusions of poisoning, and that she was duly discharged when sufficiently recovered, and would have been so with or without her friends' consent. We can hardly recommend a more salient and striking example to anyone who wishes to see what a portentous "case for investigation" can be easily gotten up by many a discharged lunatic. We had ourselves made up our minds, on reading the testimony, that "some one had blundered," until we came to the

statement of the superintendent himself, armed with the documents and real history of the case. Dr. Maury Deas appears very creditably in the whole matter, and even goes beyond the limits of his own responsibility to point out that the only error in the case was the deception practiced upon the patient to inveigle her into the asylum, a course which the doctor, in common with all of us, greatly reprobates, (see 7,709–7,905). Dr. Deas also expressed some very strong views against the consignment of curable cases to work-houses, and wished the law modified so as to make the lunatic wards of work-houses, places of custody for the chronic and harmless cases. In this he appears to agree with Dr. Maudsley, that a difference might be made in the procedure for committing recent cases to asylums, and that for disposing of quiet and chronic cases in work-houses, or under private care. The "certificate of emergency," (to be verified within three days after commitment), in Scotland, appears to answer a similar purpose, while under the New York statute security is provided by the requirement that the certificates must be approved by a judge of a court of record within five days. Another curious thing that comes out in Dr. Deas' testimony, is that it is a very common thing for relatives to enter a patient as a pauper, and then pay the board of guardians the usual price for his support. This was done in Mrs. Petschler's case, her sister meeting the payments. The object appears to be to obtain some of the privileges of private patients, without the full cost of such. One reason of this may be that the obviously just distinction which our law makes between the class of "indigent persons" and paupers does not prevail in England.

I.

We have seen that with all the safeguards which legislation can devise against improper commitment to an insane asylum, the medical certificates, resting on the integrity and scientific skill of the profession, must be the principal protection. And the testimony of actual experience shows that as a general rule this safeguard may be relied upon with the utmost confidence. Very rarely, indeed, has a mistake been found in such a certificate; the tendency is rather in the opposite extreme, to withhold such certificates too long for the good of the patient.

It may well be supposed that the question of improper *detention* in asylums, after discharge becomes expedient, is a more serious and difficult one to provide for. On this point we prefer to extract from the testimony, leaving our readers to draw their own inferences. The following answers were given by Mr. C. S. Perceval, Secretary to the Commissioners in Lunacy:

*Q.* I suppose if there is any abuse it is more likely to be caused by detaining a person rather too long in the asylum, than in taking him in when it is unnecessary? *A.* Yes, I believe the evidence of Lord Shaftesbury, in 1859, went very much to show that the real danger was not so much the taking in of any person who had no unsoundness about him, as in keeping him in rather too long, not always from an improper motive, although it is easy to assign an improper motive, namely, to get more money; but, of course, that is also consistent with over caution.

*Q.* I asked the question because it was a question which was distinctly asked in the former inquiry of Dr. Conolly; he stated that the profit was so small that there was no inducement to take in or keep in anybody unjustly; you have not considered that point perhaps? *A.* No, there are some of those houses in which patients are taken in paying very large sums, but in the same houses I know there are sometimes patients who are paying very small sums; I would rather not venture any opinion upon that matter at all, for I simply do not know anything about it practically.

*Q.* When the Commissioners in Lunacy think that a patient is beginning to recover, is there special attention directed to him? *A.* Yes, always; there is special attention directed to that patient; it is their constant practice to note in the "Patients' Book," which is one of those statutory books which is obliged to be produced upon every occasion, the name of every patient who is supposed to be getting better, and they make suggestions as to his having a trial on leave. That book is submitted to the next people who come, whether Commissioners or visitors, and inquiry is made whether the suggestion has been carried out. In fact, when we get the entries in the "Patients' Book," (they are all sent up, both the entries made by the Commissioners and visitors too), we look at the cases referred to in the "Patients' Book;" all those cases are kept under observation, and it is some clerk's duty to keep them under his eye and bring them before me; and if it appears that A. or B. has not gone on leave, a letter is written asking the question. How is it that A. or B. has not gone on leave as suggested, and then the answer comes either that his friends have nowhere to send him, or that he is going next week, as the case may be.

*Q.* Have the Commissioners themselves power to discharge in case they think the patient ought to be discharged? *A.* Yes. The Commissioners are entitled to order the discharge of a patient in a licensed house or hospital, provided it appears to them after two special visits, and after giving notice to the friends, and after a proper amount of inquiry, that there is not sufficient cause for his detention. The Act does not say that the Commissioners are to express an opinion that the patient is cured, or that he is not insane, but there is not sufficient cause for his being detained under care and treatment.

*Q.* Nor have there been any complaints made, suggesting that patients have been improperly retained in the asylums? *A.* I do not know about complaints made. The Commissioners, from their own observations, sometimes think that a patient ought to be allowed to go, and their friends sometimes think that it is not time that they should be discharged. It is more in the case of pauper patients that we hear these complaints, than in the case of private patients. A near relation wishes to get the bread winner of the family out of the asylum, or the husband wants to get his wife back, because he finds it very uncomfortable to be living without her, and he wishes her to be discharged, whether she is quite cured or not; those are the kind of complaints we get in much

larger numbers than those relating to the undue detention of private patients.

*Q.* You do not think that there is any ground for believing that people, who are once received, are improperly retained in those houses? *A.* There may be sometimes a question of degree, whether the patients might not have been discharged a short time sooner than they were discharged; but with that qualification, I should say not.

Mr. Wilkes, a Commissioner in Lunacy, and formerly Superintendent of the Stafford County Asylum, gave the following testimony:

*Q.* Is it not excessively difficult to judge of the sanity of a patient by talking to him? *A.* Very often very difficult.

*Q.* Have they in many cases, except perhaps the worst, or even perhaps without that exception, the power of self-restraint, which lasts for a certain time? *A.* Very strongly. Of course there are a great number of chronic cases unfortunately, both in asylums and licensed houses, whose state any one experienced in the matter would see by their aspect; but there are other cases where it is very difficult indeed to ascertain the lunacy of the patient. I may state as to the case I mentioned just now, where we had to visit specially, that there were two medical officers in this asylum, and they both reported, one under the statutory order, within seven days, that he did not see any insanity about the patient. We had a further report from the chief medical officer, confirming that to a great extent, upon which we visited, but we found the patient in a short time to be full of delusions, to be as insane as possible, and no doubt a dangerous lunatic, and yet he had concealed all his delusions during a fortnight or so from the two medical officers of that establishment. He admitted it afterwards; he said, "Well, you dragged it out of me," and he intimated that we had not at all got to the bottom of his delusions; that he had many more.

*Q.* He stated so himself? *A.* He stated so himself.

*Q.* Is it a fact that many patients who can not be depended upon when speaking about themselves, can be depended upon when they are talking about others, or about the treatment that others have received? *A.* Very frequently, and we have received from patients, under those circumstances, when we have had investigations to make, very reliable evidence as to the treatment of others in asylums.

*Q.* As to the conduct of attendants, for instance, and circumstances of that kind? *A.* Quite so.

*Q.* You said just now that in the case of pauper asylums, superintendents have no reason to keep them longer than they can help? *A.* Of course their object is to discharge them.

*Q.* In the case of private asylums there is a direct interest in retaining them? *A.* I do not think so.

*Q.* There may be? *A.* I do not think so. I think the interest of the proprietors of private asylums, generally, is to discharge them, and to show their lists of recoveries.

*Q.* Do you think it is invariably so? *A.* I do not know that it would be in the case of a chronic patient, who is absolutely insane; of course if a proprietor had a patient of that description he would not like the patient to be removed to another house; I think that is a natural feeling, but I do not think, as far as I can judge, that if the friends wished to remove that patient any obstacle is placed in the way.

*Q.* You see no objection to having a proprietor of a private asylum pecuniarily interested in the asylum? *A.* I do not see how you could provide otherwise for it.

*Q.* Do you consider that the line between sanity and insanity is so distinct that individuals who are insane can easily be distinguished from those who are not? *A.* That is a very doubtful matter; I think the line is very indistinct, and I believe there are a great many persons who are out of asylums who are not of sound mind. For instance, there are all the lamentable instances that we have of murders by people who are no doubt insane; the number of suicides which take place, especially such cases as recently occurred in London, where most valuable lives have been sacrificed for want of proper care. From a return which I obtained from the office of the Registrar General, which is at present not published, it seems that during the year 1875 there were about 1,600 persons in England alone who committed suicide. The great majority of them were probably insane, and they committed suicide for the want of proper care.

*Q.* They were persons whom you regard as responsible for their actions? *A.* No, I do not know that; I think many of them probably were perfectly insane and irresponsible.

*Q.* Is it your opinion that any person who is guilty of a heinous crime is necessarily to be regarded as insane? *A.* No, certainly not; I do not look upon all who commit suicide as insane, or upon all persons who commit murder as insane, but the great majority of them are.

*Q.* If the line between sanity and insanity be in itself indistinct, it would require great caution to provide against the possible detention of those who are sane? *A.* Quite so; but I do not think that those persons in whom the line is so indistinct, come under the class of patients who are received into asylums. As to the latter, generally speaking, there is no question as to their insanity. It is not those questionable cases that are certified and sent to asylums.

This witness as well as Mr. Perceval stated that the commissioners in lunacy, by virtue of their own powers, by statutory order, had not discharged from asylums over ten persons since 1845, showing the general correctness of proceedings, and the judgment of the medical superintendents.

The next witness was Dr. Lockhart Robertson, one of the three Lord Chancellor's Visitors in Lunacy. His testimony related only to chancery lunatics, about one thousand in number, who are scattered about partly in county asylums, and partly in licensed houses or private dwellings.

*Q.* It is a great temptation, is it not, to retain the management of a large property on the part of the committee? *A.* The management is in the hands of the court; the committee have not much discretion in the management of the property.

*Q.* But the committee, I suppose, has, in the case of a lunatic of large property, a very considerable allowance? *A.* Yes, he has.

*Q.* Which is to him a livelihood? *A.* Yes, he has a considerable allowance in certain cases.

*Q.* He is a person who would be anxious, if he were not a well-principled man, to keep the patient longer under his care than he ought? *A.* Yes; whenever we think a patient recovered, we always communicate to him and to the patient also that we consider the patient recovered, and that a petition must be presented.

*Q.* If some means could be devised by which no profit whatever, and no advantage could be obtained by the people in charge of the lunatic, do not you think that would be safer? *A.* I think

it would, certainly. I think if the committees of the person were obliged to submit accounts to the court, it would certainly be safer, but there would be difficulty in doing it where a patient lived in the house with the committee.

*Q.* Have you formed any opinion as to what proportion of patients are detained after they ought to be discharged? *A.* Do you mean of the Chancery patients?

*Q.* Yes? *A.* I do not think there are any detained after they ought to be discharged.

*Q.* With reference to the lunatics generally, have you formed any opinion upon that point? *A.* I think lunatics generally are detained too long in asylums; and I think a large number of lunatics who are in asylums, probably one-third, might be out of asylums. I am speaking of private patients now.

*Q.* I asked a question the other day whether the medical certificate might be made terminable at a certain time, and renewable, instead of being permanent; what is your opinion upon that point? *A.* I heard you ask the question, and it struck me at the time that it was a most admirable suggestion; I was much struck with the question at the time.

*Q.* The objection stated to it was that it would be an unnecessary expense to those who could not afford it? *A.* I think it would be a very good investment for those who could.

*Q.* Your opinion is in favor of it? *A.* Decidedly.

*Q.* You think, I suppose, that a more minute examination of the case would take place than at an ordinary visit? *A.* Yes, there would be such a special examination by some physician who would be supposed to have some special knowledge of the subject.

*Q.* You would add to that suggestion this, that the persons who renewed the certificate, should be a special class, and not simply medical men taken from here, there and everywhere? *A.* Quite so. I think they ought to have some special evidence of their fitness for their difficult duty.

*Q.* You would have the ordinary certificate left as it is for the first confinement, but that when it is renewed, it should be renewed by people possessing a special knowledge of lunacy? *A.* I think so, at least skilled physicians. I do not think the special knowledge of lunacy is so important as being a well educated physician.

*Q.* People in very considerable practice? *A.* Yes, the leading men in each district.

Dr. Robertson declared that he never knew of one wrongfully detained, even in pauper asylums, but he

thought more of the private patients ought to be in public asylums. He stated the fact that in Scotland 80 per cent of the private patients are in the chartered asylums, while in England there are only 48 per cent. His suggestion as to the renewal of certificates, involving a periodical review of each case, certainly deserves consideration as bearing upon this question of too long detention; but the continuous history provided for in the case-books, and their accessibility to the visiting commissioners *ought* to meet the case. He also thought that it is a great shock for patients of the upper classes to be sent to public asylums, when they could be taken care of by some medical man who has but three or four under his charge. We supposed that this alternative was already open in the licensed houses. It appears, however, that chancery visitors have no control over private asylums, and can only make recommendations to the committee of the lunatic, who is not obliged to accept them, (950). Dr. Robertson is also in favor of the Scotch system of boarding out harmless chronic patients, and speaks highly of Kennaway, a sort of imitation of Gheel, and he believes that one-third of the patients now in asylums would be better out, as not really "dangerous to the public," (1,055). He quoted from Dr. Maudsley's "Pathology of the Mind," a passage sustaining this view, (1,057). Of course this is practicable only where friends or relations are able to pay for their private care, or are ready to accord such care themselves. On the general question, however, Dr. Robertson summed up his evidence as follows:

*Q.* Are you decidedly of opinion that the safeguards against the improper admission and detention of persons in asylums, hospitals and licensed houses are practically sufficient, and that a more complicated system of checks would do more harm than good? *A.* Yes, decidedly.

*Q.* You would put it that at long intervals, and in rare cases, mistakes as to people's sanity would necessarily occur? *A.* Yes.

*Q.* But not more frequently than in cases where innocent people are arrested, tried, and even convicted? *A.* No, certainly; about the same, I should think.

*Q.* In fact, the same fallability of judgment which affects the one affects the other? *A.* Exactly.

Dr. Crichton Browne, another of the Lord Chancellor's visitors, disagreed with Dr. Robertson in several particulars. He believes abuses are more likely to occur in private houses than in public or private asylums, and does not at all believe that one-third of the present patients in asylums could be boarded out. He would have dispensaries attached to asylums, for persons threatened with first attack or relapse, for their immediate treatment. He made the following very clear and satisfactory statement of his experience as to admissions and detention:

*Q.* Is there anything else you wish to state? *A.* I may say I have admitted upwards of 5,000 patients into a public asylum, and have had myself to certify them, and I do not recollect one case in which a person had been sent fraudulently, or out of malice or ill will. Out of that number I have had at the end of the week to certify perhaps ten or twelve as "not insane;" as having shown no symptoms of insanity during their residence in the asylum. In all those cases, when I have inquired into them, it has been an error of judgment that has led to their confinement, or there has been a transient attack of insanity when the certificate was signed, and that has subsequently passed away; there have been no symptoms of madness in the asylum, consequently I have certified "not insane," and the patient has been immediately liberated. A more considerable number of patients I have been unable to certify at the end of seven days. They have been insane at the period of admission, but rapid recovery has taken place. Sometimes the mere fact of removal to the asylum, and the altered circumstances, induce recovery. I have seen reason restored within a few hours of admission, and those cases were certified as convalescent, after an attack of insanity, and were discharged after

a very short period. I have heard the allegation made that there has been a fraudulent intention or malice on the part of the relatives in shutting up the patient, but I have never been able to make out a case in which that was substantiated.

*Q.* Is it your opinion that in private asylums patients are kept longer than they ought to be after cure? *A.* My colleagues, who have had much more experience than I, hold that belief. I can not say that I have myself come upon a case officially. When practicing as a physician I saw one or two cases in private asylums in which convalescence was, to my judgment, unnecessarily protracted, but I attributed that to an excess of caution rather than to a discreditable motive.

*Q.* Is it your opinion that the credit of an asylum and its character for frequent and rapid cures would be more valuable than the extra profit gained by keeping the patient unduly long? *A.* Quite so; and the larger the asylum is the more does that operate. Where there is only a single case, or a few cases, it might be of great importance to retain them; but in a large asylum the proprietor has more interest in the character of the establishment than in the detention of any one case.

Dr. Browne thinks the existing safeguards are sufficient, and further checks would do more harm than good. He also states that about 20 per cent (no more) of the insanity of the country is due, directly or indirectly, to intemperance. From Dr. Bucknill's testimony we select the following points:

*Q.* You have traveled a good deal in America, and examined the state of things there, can you tell us what the American law is with regard to the admission and detention of patients in asylums? *A.* It varies in every State. I have not yet been able to get a reply to letters of inquiry which I have written, but I hope to be able to give you information on that point. A good deal of change has taken place quite recently. The State of New York seems to have made the best change. There, the certificates before the year before last could be signed by any two men, calling themselves medical men. The new law requires that they shall be qualified medical men, and that they shall also have a certificate from some judge of a court of record, to whom they are personally known as

competent for their duties, so that in that way an attempt is being made to create a class of medical men who understand something about insanity, and are capable of giving certificates.

*Q.* If you made an alteration with regard to the person signing the order, do you not think it would be a proper provision to make, that the person signing the order, or some friend or friends on his behalf should be compelled to visit the patient in the asylum or licensed house, within say three months of his reception? *A.* Yes, I think so; I think it ought to be done. I see that in Lord Shaftesbury's evidence, which is most full and valuable, before the old committee of 1859, he lays great stress upon the hardship which lunatics suffer from the neglect of their friends, when they are once in an asylum. The committees of chancery patients are expected to visit their charges once in every three months; and it would be a proper regulation, I think, that the person who signs the order for the admission of a private patient into a private asylum should be required to visit at certain intervals.

*Q.* You said the cases of sane persons being improperly confined, or improperly detained, were exceedingly rare, as far as your experience went? *A.* Yes.

*Q.* Your experience extends over how long? *A.* Thirty-two years altogether, officially in a county asylum, and as the Lord Chancellor's Visitor.

*Q.* During that period, how many cases can you call to mind; how many have come under your cognizance? *A.* I can remember five cases as Chancellor's Visitor; one of those had escaped before I examined him.

*Q.* Do you find that patients after they are discharged, are in the habit of making complaints to the visitors or to the board? No, very rarely. There are a class of patients who are never quite insane and never quite recovered, who make complaints as long as they live after they have been put into an asylum, but there are not many of them.

*Q.* In cases of the recovery of a patient, do you find that there is a sense of injustice in their minds with regard to their detention in the asylum? *A.* I am afraid that is not very infrequent.

*Q.* Do they generally admit that it was a good thing for them to have been there, or do they generally suppose that they might have done quite well without having gone there? *A.* It will vary very much with the asylum in which they have been placed.

If they have been placed in an asylum where they have been treated as friends, and they have found it a cheerful, pleasant home, feelings such as you describe are not likely to arise. In an asylum of a different character, where there has been a strict discipline, and they have had a routine life which has been very irksome to them, it would be otherwise.

*Q.* Have you considered whether easy discharge from asylums would tend to the more frequent admissions of patients in the early stages of the disorder, and to the early treatment of the disease? *A.* Sir James Coxe has clearly pointed out that not only the highest percentage of cures, but the shortest duration of treatment in Scotland is found in the Renfrewshire asylums, which are parochial asylums in which the inspectors of the poor can put a patient on the outbreak of insanity, without any difficulty, and can also remove him without any difficulty, whatever. He points out that the authorities of asylums may perhaps unwittingly increase the indisposition to place patients in asylums by throwing impediments in the way of their easy removal from asylums. I take it that the succession of events which Sir James points out is this, that you get easy discharge from these Renfrewshire parochial asylums; therefore you get early admission; therefore you get early treatment, and a much larger percentage of cures effected in a shorter time.

Dr. Bucknill thinks some restrictions should be imposed as to the person allowed to sign the order, and complains of too much power given to committees and persons signing orders to disregard advice of medical officers, and to obstruct discharge, even when expedient for the patient, making great delays in reaching the chancellor or his deputies or the commissioners. He favors the Scotch plan of making the certificates terminable and renewable.

As to the practice in Scotland, Sir James Coxe testifies:

*Q.* What provision is there for taking patients out of custody, or detention, and restoring them to liberty? *A.* In the original Lunacy Act, the only person who could take patients out of asylums was the sheriff. The sheriff had, and still has the power,

upon receiving certificates from two medical men that the patient had recovered, or that the patient was in a state fit to be discharged, to order the removal of the patient. A like power was given to the commissioners, but restricted to recovered patients. They could not order any unrecovered patient to be taken out of an asylum. Of course, the party who places a patient in an asylum can take him out at any time.

*Q.* Without the leave of the superintendent? *A.* Unless the superintendent certifies that he is in a dangerous state.

*Q.* Supposing the superintendent considers that the patient ought not to be let out, and the relations do not want him to come out, but still he is sane, in such a case as that what chance is there of the patient being taken out? *A.* He would appeal to the commissioners at their visits, and if they saw reason to think that he was sane, they would send two medical men to examine him; it is a frequent procedure with us. The difficulty with us is that we seldom get certificates of complete sanity, and then we fail to get the patient out.

*Q.* Unless you get a certificate of complete sanity? *A.* Yes; they may appeal to the sheriff, but they seldom do that. I scarcely remember a case of such an appeal to the sheriff. There are difficulties in the way, chiefly of a pecuniary character.

*Q.* Then does the patient remain in the asylum? *A.* Yes.

*Q.* Though he is an improper person to be there? *A.* He is not, perhaps, an improper person to be there; but he is a person who might be out. It is difficult to say exactly what is a proper person to be in an asylum; there is statutory reason for his detention.

*Q.* It is the case, is it not, that when a patient has arrived at a certain point in cure, detention in the same asylum is bad, and that he ought to have a change? *A.* A change is very frequently of great advantage to him.

*Q.* You can not compel it? *A.* We can not compel that. Several of the asylums have country houses; they have houses in the country where they send certain of their patients for a change. We often have an opportunity of recommending the friends of private patients to give them a change. Sometimes we recommend the inspectors of poor to give a change to a pauper patient; they generally do it.

*Q.* Do you ever discharge patients on probation? *A.* Yes, very frequently; generally before giving their final discharge. It is a test to see how they get on amongst their friends in private dwellings.

*Q.* At the end of that time can they be received without a fresh order? *A.* The discharge of a patient is granted for a certain time not exceeding twelve months. It may be for three or six months, and any time within the limit for which the discharge has been granted, they may be sent back to the asylum; just taken back, and they are admitted without any forms at all.

Sir James hardly endorses the necessity of immediate asylum treatment in all cases where a person has the means to obtain other kinds of treatment, such as travel, &c. He is very strong against the practice of admitting habitual drunkards again and again, and did not know of an instance of permanent cure of such a patient. He believes in the boarding out system for insane, though not in "colonies," where they are herded together. He has never known of a case wrongfully committed or detained after full recovery.

On this whole subject of the possibility of wrongful detention, we suppose that the contingencies can not be better expressed than in the following answers of Sir James Coxe.

*Q.* With reference to the protection by visits of the commissioners, or medical men, I suppose there are many cases where a man might be insane, although upon a visit and conversation with him, no symptom of insanity would appear? *A.* Yes.

*Q.* Therefore, to some extent, persons paying such visits are guided, I presume, by the statements they receive from the superintendents of the asylum? *A.* Yes, they must be, to a certain extent. When we send medical men, we often get a reply to say, "We had a long conversation. We observed no symptoms of insanity, but from what we were told by the superintendent, and what we saw in the case-books, we are of opinion that the patient is still insane, and therefore we decline to grant certificates of sanity."

*Q.* So that if you had a case of an unscrupulous superintendent who, for his own purposes, was seeking to detain a sane man, it would be possible for him to do so, notwithstanding the visits of the commissioners, or the visitors? *A.* I think the commissioners would satisfy themselves, without difficulty, in such a case as

upon receiving certificates from two medical men that the patient had recovered, or that the patient was in a state fit to be discharged, to order the removal of the patient. A like power was given to the commissioners, but restricted to recovered patients. They could not order any unrecovered patient to be taken out of an asylum. Of course, the party who places a patient in an asylum can take him out at any time.

*Q.* Without the leave of the superintendent? *A.* Unless the superintendent certifies that he is in a dangerous state.

*Q.* Supposing the superintendent considers that the patient ought not to be let out, and the relations do not want him to come out, but still he is sane, in such a case as that what chance is there of the patient being taken out? *A.* He would appeal to the commissioners at their visits, and if they saw reason to think that he was sane, they would send two medical men to examine him; it is a frequent procedure with us. The difficulty with us is that we seldom get certificates of complete sanity, and then we fail to get the patient out.

*Q.* Unless you get a certificate of complete sanity? *A.* Yes; they may appeal to the sheriff, but they seldom do that. I scarcely remember a case of such an appeal to the sheriff. There are difficulties in the way, chiefly of a pecuniary character.

*Q.* Then does the patient remain in the asylum? *A.* Yes.

*Q.* Though he is an improper person to be there? *A.* He is not, perhaps, an improper person to be there; but he is a person who might be out. It is difficult to say exactly what is a proper person to be in an asylum; there is statutory reason for his detention.

*Q.* It is the case, is it not, that when a patient has arrived at a certain point in cure, detention in the same asylum is bad, and that he ought to have a change? *A.* A change is very frequently of great advantage to him.

*Q.* You can not compel it? *A.* We can not compel that. Several of the asylums have country houses; they have houses in the country where they send certain of their patients for a change. We often have an opportunity of recommending the friends of private patients to give them a change. Sometimes we recommend the inspectors of poor to give a change to a pauper patient; they generally do it.

*Q.* Do you ever discharge patients on probation? *A.* Yes, very frequently; generally before giving their final discharge. It is a test to see how they get on amongst their friends in private dwellings.

*Q.* At the end of that time can they be received without a fresh order? *A.* The discharge of a patient is granted for a certain time not exceeding twelve months. It may be for three or six months, and any time within the limit for which the discharge has been granted, they may be sent back to the asylum; just taken back, and they are admitted without any forms at all.

Sir James hardly endorses the necessity of immediate asylum treatment in all cases where a person has the means to obtain other kinds of treatment, such as travel, &c. He is very strong against the practice of admitting habitual drunkards again and again, and did not know of an instance of permanent cure of such a patient. He believes in the boarding out system for insane, though not in "colonies," where they are herded together. He has never known of a case wrongfully committed or detained after full recovery.

On this whole subject of the possibility of wrongful detention, we suppose that the contingencies can not be better expressed than in the following answers of Sir James Coxe.

*Q.* With reference to the protection by visits of the commissioners, or medical men, I suppose there are many cases where a man might be insane, although upon a visit and conversation with him, no symptom of insanity would appear? *A.* Yes.

*Q.* Therefore, to some extent, persons paying such visits are guided, I presume, by the statements they receive from the superintendents of the asylum? *A.* Yes, they must be, to a certain extent. When we send medical men, we often get a reply to say, "We had a long conversation. We observed no symptoms of insanity, but from what we were told by the superintendent, and what we saw in the case-books, we are of opinion that the patient is still insane, and therefore we decline to grant certificates of sanity."

*Q.* So that if you had a case of an unscrupulous superintendent who, for his own purposes, was seeking to detain a sane man, it would be possible for him to do so, notwithstanding the visits of the commissioners, or the visitors? *A.* I think the commissioners would satisfy themselves, without difficulty, in such a case as

that. If such a man came up and appealed, I do not think they would be readily convinced that he was insane. We have no power of liberation ourselves, and if we send medical men, and the medical men choose to take that view, and to be guided by the superintendent, then the patient can not get out.

*Q.* I am not saying what alteration could or should be made, but the visits which are made from time to time are not a complete protection against a person being improperly detained if the superintendent of the asylum were unscrupulously intending to detain him? *A.* No, but practically, I think it is. I do not think there is any great risk.

Dr. Harrington Tuke, of Chiswick Manor, a private asylum, (2,554), holds that the rate of cure is higher in private asylums, with a medical head, than in public asylums, and says there is more of domestic care and association for convalescents, (2,548). He also scouted the idea that patients were sometimes prepared by drugs for receiving visitors. The average in private asylums is about twenty-three patients to each physician. As to the irksome confinement in asylums, and the difficulty of sufficient employment, Dr. Tuke very sensibly says, "If a man is suffering under a disease he must suffer what the disease entails upon him, and the only thing is to get him well as soon as we can."

Dr. Nugent, one of the two inspectors of asylums in Ireland, gave a description of the general arrangements in criminal asylums in that country. Commitments are restricted to the greater crimes, lesser offenses being often only an evidence of the insanity. Patients have free access, by correspondence, to the inspectors, who may call in a consulting physician, and discharge a patient if they see cause, (2,728). The number of lunatics in Ireland, including paupers, is 18,100; 680 in private asylums. It is because public asylums are crowded with chronic and pauper cases, that the statistics of cure compare unfavorably with private asylums,

when generally only recent or curable cases are taken. Dr. Nugent knows of no cases of improper commitment or wrongful detention.

In the cases of Mrs. Lowe, Mrs. Petschler, Rev. W. A. O'Conor and others, which were gone into on their own testimony, it came out clearly enough that there was marked insanity in each one, but it also came out that the signer of an order is practically omnipotent, and that the person who places a patient in an asylum may prevent any access to him or her by third parties, other than the commissioners or inspectors, without his consent.

Dr. Maudsley would abolish that clause in the law by which a medical superintendent can, in any case, prevent the removal of a patient by certifying that he is "dangerous," and Dr. Robertson believes that there should be an independent physician appointed as visitor to each private asylum, to be responsible to the Commissioners. Dr. Blandford, however, does not agree with this, except as it is meant to increase the number of commissioners, (7,415). He testified that as a proprietor of a private asylum he was more led to yield to pressure of friends to discharge patients, who certainly would be kept longer in a public asylum.

Upon a review of the whole evidence, which indeed goes into every detail of treatment and asylum administration, as well as the question of safeguards to personal liberty, the conclusion drawn is, that the only possibility of unfair dealing lies between the party placing a person in confinement and the medical superintendent of the institution. Experience of facts shows that fraud and collusion, even in this state of things, rarely, almost never occur. Its absolute impossibility might be secured, as it is by the law of the State of New York, by the interposition of a magistrate's author-

ity, between the party sending the patient and the authorities to whose custody he is committed. And yet Mr. Palmer Phillips, one of the commissioners in lunacy, very decidedly prefers the law should be left as it is in England, believing that the best safeguard is the individual liability of the person himself, at whose instance any one is deprived of his liberty on the ground of insanity.

*Q.* You do not think it would be a good plan to try to assimilate the English system to the Scotch system, that the relation, or whoever the party was who wanted the patient shut up, should petition some public authority for the order? *A.* My own idea is that if you substitute any magistrate or official person as the party to sign the order, it will be most mischievous to the liberty of the subject, and very prejudicial to the alleged lunatic, for this reason; there is, I think, no greater safeguard for the due performance of a duty than individual, personal responsibility. Such responsibility, if it is not duly exercised, a jury will visit with damages, and in cases of false imprisonment juries give very heavy damages. At the present time the responsibility is such that very many decline to take it upon themselves for the benefit of the lunatic, even when his benefit loudly demands it. I think that this safeguard is very well supplemented by certificates and reports, and by visits by the commissioners and others. If you allow a magistrate either to sign the order or to countersign the order, you will at once destroy all the responsibility of the relative or other person. If a person is falsely imprisoned under a magistrate's order there can be no remedy. If the magistrate has acted *bonâ fide* he will be relieved from all responsibility; he can not be visited with a verdict for damages, and there will be no remedy for the lunatic. Besides, the magistrate will become simply a ministerial officer in the matter, and will be guided, if not absolutely, to a very great extent, by the certificate, so that really it will come to this, that the only safeguard will be the certificates. The great safeguard now is the responsibility of the individual who signs the order.

We have purposely refrained from bringing into this analysis, the evidence of Lord Shaftesbury, it being

of sufficient extent, interest and value to furnish the materials of an article by itself. Lord Shaftesbury has been on the Lunacy Commission, for about fifty years, and its permanent chairman since 1845, and thus has been witness and participant in all the vast improvements that have been made during that period in the asylum system of the world. We are sure that we shall be justified in giving separate and special attention to the views of this veteran in all that pertains to insanity.

# THE STRUCTURE OF THE VESSELS OF THE NERVOUS CENTERS IN HEALTH, AND THEIR CHANGES IN DISEASE.

BY THEODORE DEECKE.

## IV.

We proceed to the description of the vascular arrangements in the central grey ganglia of the brain, including the ependyma of the ventricles, the internal capsule, the commissura beseosa alba, the laminæ septi lucidi, the external capsule and the claustrum. It is well known that the central ganglia are, more frequently than other parts of the cerebrum, the seat of lesions of the vascular system; that intracephalic hæmorrhages are, in general, much more common in these centers than in the peripheral parts. It may, however, be remarked that this does not hold in reference to the brains of the insane. This frequency of hæmorrhages is unquestionably largely influenced by the mode of arterial supply in the parts mentioned, a fact to which Duret, Heubner and others have called our attention. The arteries or the arterioles, which enter these masses, originate directly from the main trunks at the base of the brain. They are smaller in number, but larger in diameter than those which penetrate the grey cortex of the convolutions. They are terminal arteries in the strictest sense of the word, as they break up entirely into capillaries, which are, likewise, of considerably larger transverse diameter than those in the peripheral ganglia. This mode of arterial supply isolates the central masses almost entirely from the cerebral periphery. The area of circulation is, therefore, here much

less extended, the pressure of the blood higher, and, aside from the greater capacity of the capillaries, there exists no other provision to counterbalance deviations from the normal supply of blood which result from an increase or decrease in the action of the heart. These conditions are evidently favorable to arterial ruptures. On the other hand, however, it should not be forgotten that the vigorous development of the capillary system must facilitate absorption. It also affords less danger of the setting in of inflammatory changes by the diapedesis of the white corpuscles of the blood, a condition which has been exceedingly rarely observed in these parts of the encephelon.

The vascular arrangements in the cerebellum are much like those in the cerebral hemispheres. The connective tissue envelop is absent in the cerebellar convolutions, and the border layer of fibrous tissue is developed in a smaller degree. We distinguish three layers, viz.: the grey, the round cell, and the white layer. The ground substance of the grey layer, with its comparatively small number of nuclei, is of the same nature as that of the cerebral convolutions. It receives its prominent feature from the large number of the great ganglion cells at the border of the round cell layer, which send their ramifications, like the roots of a tree, through the whole thickness of the grey layer. They run out into branchlets so delicate that they can not be distinguished from the fine granular matrix in which they are imbedded. Anastomoses between the processes inter se, or between the processes of different cells, have never been observed by myself. One process, given off in the direction toward the round cell layer, penetrates this layer, and terminates in a nerve fiber in the white layer. There are two classes of arteries which penetrate the cerebellar convolutions.

# THE STRUCTURE OF THE VESSELS OF THE NERVOUS CENTERS IN HEALTH, AND THEIR CHANGES IN DISEASE.

BY THEODORE DEECKE.

## IV.

We proceed to the description of the vascular arrangements in the central grey ganglia of the brain, including the ependyma of the ventricles, the internal capsule, the commissura besœosa alba, the laminæ septi lucidi, the external capsule and the claustrum. It is well known that the central ganglia are, more frequently than other parts of the cerebrum, the seat of lesions of the vascular system; that intracephalic hæmorrhages are, in general, much more common in these centers than in the peripheral parts. It may, however, be remarked that this does not hold in reference to the brains of the insane. This frequency of hæmorrhages is unquestionably largely influenced by the mode of arterial supply in the parts mentioned, a fact to which Duret, Heubner and others have called our attention. The arteries or the arterioles, which enter these masses, originate directly from the main trunks at the base of the brain. They are smaller in number, but larger in diameter than those which penetrate the grey cortex of the convolutions. They are terminal arteries in the strictest sense of the word, as they break up entirely into capillaries, which are, likewise, of considerably larger transverse diameter than those in the peripheral ganglia. This mode of arterial supply isolates the central masses almost entirely from the cerebral periphery. The area of circulation is, therefore, here much

less extended, the pressure of the blood higher, and, aside from the greater capacity of the capillaries, there exists no other provision to counterbalance deviations from the normal supply of blood which result from an increase or decrease in the action of the heart. These conditions are evidently favorable to arterial ruptures. On the other hand, however, it should not be forgotten that the vigorous development of the capillary system must facilitate absorption. It also affords less danger of the setting in of inflammatory changes by the diapedesis of the white corpuscles of the blood, a condition which has been exceedingly rarely observed in these parts of the encephelon.

The vascular arrangements in the cerebellum are much like those in the cerebral hemispheres. The connective tissue envelop is absent in the cerebellar convolutions, and the border layer of fibrous tissue is developed in a smaller degree. We distinguish three layers, viz.: the grey, the round cell, and the white layer. The ground substance of the grey layer, with its comparatively small number of nuclei, is of the same nature as that of the cerebral convolutions. It receives its prominent feature from the large number of the great ganglion cells at the border of the round cell layer, which send their ramifications, like the roots of a tree, through the whole thickness of the grey layer. They run out into branchlets so delicate that they can not be distinguished from the fine granular matrix in which they are imbedded. Anastomoses between the processes inter se, or between the processes of different cells, have never been observed by myself. One process, given off in the direction toward the round cell layer, penetrates this layer, and terminates in a nerve fiber in the white layer. There are two classes of arteries which penetrate the cerebellar convolutions.

The one, the smaller in size and the larger in number, arise from the second arterial network of the pia mater. They are, in fact, nutrient arteries, which run out into the finest capillary network in the grey layer. The second class consists of larger stems, which originate in the first network of the pia mater. They do not commonly send off any branches before they have reached the round cell layer, in which the branches break up into a capillary network almost as dense as that of the grey layer. The main trunk then enters the white layer, following the course of the fibers, gradually dividing and passing over into capillaries. Hæmorrhages in the cerebellum are not so very rare; they occur mostly in the white substance. The ganglionic layer, as it will be seen from our description, is as well protected against extensive or permanent derangements of the vascular system as the grey cortex of the cerebrum.

The vascularization of the pons Varolii, of the medulla oblongata, and of the spinal cord, is in accord with the distribution of grey and white matter in the same. The grey centers and tracts are exceedingly rich in capillaries. The pons receives its supply from the branches of the basilar artery, which likewise form two arterial networks in the pia mater; the upper part of the medulla oblongata from branches of the two vertebral arteries, and the lower part from the spinal arteries. The larger stems, which penetrate these organs, are located in the raphé, and accompany the roots of the nerves.

The part of the central nervous system which is undoubtedly the best protected against sudden and serious alterations in the blood supply, is the spinal cord. The two main arteries, the anterior and the posterior arteria spinalis, are of comparatively small

size. They originate from two branchlets given off at an obtuse angle from the two vertebral arteries, and are of about the same transverse diameter down to the filum terminale, where they diminish in size. The anterior spinal artery sends off branches at irregular intervals to the right and left. The posterior sends off, at regular intervals, branches of smaller diameter, which follow the posterior nerve roots. Both sets of branches communicate with the intercostal arteries. At the *conus terminalis* both spinal arteries are connected by anastomoses. In their course downwards they also form a separate network of anastomoses in the pia mater, from which the finest nutrient arteries enter the cord at a right angle. Others, of larger diameter, originating directly from the spinal artery and its branches, penetrate the substance of the cord following the tracts of the nerve roots.

It is evident that by these arrangements the greatest uniformity possible in the distribution of nutrient fluid is accomplished. On the one hand, there is an ample supply, since the main source—the vertebral arteries—considerably surpass the spinal arteries in diameter. On the other hand, the latter two are in their entire length almost of the same caliber, equally dividing their contents over the whole organ, while their final communication greatly adds to the uniformity of the blood pressure in all parts of the system. But, furthermore, the connections of this system with the intercostal arteries must serve as a regulator both ways, in an increase as well as in a decrease of pressure, and a compensation is effected before any changes in the nutrient system can possibly become noticeable. This holds good as well where there is a general hyperæmia as in cases of anæmia, so far as the quantity of the blood is concerned.

From the foregoing sketch of the vascular arrangements in the central nervous system, we draw the following general conclusions in regard to the plan of organization, as well as in regard to its effect. In the animal system—that is, in those parts of the nervous centers which are absolutely necessary for the functions of organic life—there exist ample provisions for the preservation of normal conditions; while those parts in which we locate the mechanism which is concerned in the manifestations of psychical phenomena are distinguished by arrangements which facilitate a return to the normal state when this has been disturbed. In a few words, therefore, the resisting power, in regard to affections arising in the vascular system, predominates in the former, and the power of reparation distinguishes the latter. It would be easy enough to furnish ample proofs of the correctness of this view. For the present we shall confine ourselves to those conditions of the vascular system of the nervous centers, which stand in relation to the phenomena comprised under the term "insanity." And as these phenomena, from their primary stages, are invariably connected with affections of the grey cortex of the cerebrum, it would appear to be our main task first to consider the relation of these to the vascular arrangements. It is beyond discussion that, in all cases of mental disturbance, the vascular system is affected. These affections, however, may be of a secondary as well as of a primary nature. From this fact, therefore, we will have to make two sub-divisions, in the description of the changes which have been observed, namely: those which originate in the nervous centers themselves, arising through and in connection with the special mode and plan of organization which there exists; and those which are produced secondarily, developed from gen-

eral affections of the vascular system of the whole organism.

In regard to the normal, as well as to pathological conditions of the vascular system, we have to take into consideration three factors, viz.: a mechanical factor, dependent upon the physical properties of the vascular system; a physiological factor, dependent on the intervention of the nervous system; and a chemical factor, dependent upon the chemical composition of the blood. We have, first, the simple fact of the movement of a fluid in a system of elastic tubes, forced into them by the heart, a pump in constant action. This is a physical or a mechanical problem, and the phenomenon in itself is subjected to the same physical laws, or hydraulic principles, as are elsewhere valid in nature. But the effect, here, is modified, on the one hand, by energies acting upon the elastic tubes, which constantly alter their physical condition; on the other hand, by the peculiar, constantly changing constitution of the fluid which moves in the tubes. Supposing, therefore, the greatest possible constancy and uniformity of the propulsive power, the velocity of the current, as well as the pressure of the fluid in the system of tubes, will, at all times, be dependent upon the interaction of the three factors mentioned. But of these, apparently only two, the physiological and the chemical, are of variable magnitude.

The physiological factor, the influence of the nervous system, is directed to changes in the caliber of the vessels, and has become an object of wide discussion since the discovery of the so-called vaso-motor system of nerves, or, more correctly, of the existence of vaso-motor fibers, contained in the sympathetic, as well as in the cerebro-spinal nerves.

From a large number of physiological experiments it has been ascertained that the cervical sympathetic

especially, is the seat of vaso-motor fibers for the neck, the head, and, very probably, for the whole cerebro-spinal system. All vaso-motor fibers, as far as it is known at present, have, in common, one general center in the medulla oblongata, located above the upper decussation of the fibers of the anterior pyramids, in the antero-lateral section. It is represented, in its longitudinal extension, by a large, double wedge-shaped, and in transverse sections, eliptical, grey nucleus situated on both sides of the medulla, formerly known as Clarke's antero-lateral nucleus. Besides this, there is a series of sub-centers in the spinal cord.

The important office of this system of nerves is, in the way of reflex action, to maintain and to regulate the normal tone of the vessels by producing dilatation or constriction in the arterial system, and thus effecting changes in the general or local blood-pressure, and determining, according to the general and local conditions, an increase or a decrease in the flow of blood in the one or in the other direction. But a close analysis of the phenomena which follow a section or a stimulation of these nerves—the fundamental experiment by which, in the first case, a dilatation, in the second, a constriction of the corresponding arteries is produced—has shown that this simple conception does not hold for the explanation of all the facts which are observed, for the dilatation, which speedily follows the division of the nerves, disappears in the course of time, without the intervention of any other agent, and the vessels return to their normal caliber. And, further by local application, dilatation, as well as constriction, may be produced. This fact, of course, evidences that it is not solely the influence of the so-called vaso-motor system and its centers, upon which the tonicity of the vascular system depends, but that there exist

peripheral arrangements, conditions in the walls of the vessels themselves, which are capable of producing a similar effect, and by which the influence of the centers in the cerebro-spinal axis and in the sympathetic is modified.

The acknowledgment of these facts is but another proof of the functional reciprocity between the different constituents of the organism, their independence on the one hand, their dependence on the other. Under the normal state of equilibrium they generally do not come into view, but appear to be of the greatest importance in all pathological affections where this equilibrium is disturbed.

When we compare with each other the sensitiveness to the nervous influence, of the three components of the vascular system, we observe that the controlling power of the central nervous mechanism prevails in the arterial system, while the venous and the capillary system respond in a higher degree to local influences. This interesting fact, again, modifies the vaso-motor phenomena in the normal state of things, and far more, as we will see further on, in pathologically altered conditions.

As the second variable factor, which continuously acts upon the vascular system, we have announced, in the foregoing, the constitution and the chemical composition of the blood itself. This depends, for the most part, upon the interaction of this fluid with the different tissues of the organism, and upon their vital condition. Thus, we see the constant normal change in the constitution of the blood, from its arterial to its venous character, and *vice versa*, influence the velocity of the current as well as the pressure in the system. The amount of oxygen, or of carbonic acid, present in the blood, appears to be a most powerful stimulant for the nervous mechanism of the circulatory apparatus. An

increasingly venous character of the blood augments the action of the general vaso-motor center, and increases the blood pressure in the system, while the arterial character prominently affects the peripheral vaso-motor mechanism, by acting directly upon the walls of the vessels, and modifying the changes in the capillary and in the venous districts. Similar changes are undoubtedly produced by various substances accidentally introduced into the blood, or arising in the blood from natural or morbid processes. The chemical compounds originating, in the general and special change of matter, from the dissociation of the tissues and the amount of their elimination, by the function of the special excreting organs of the body, comes here into consideration. The differences in the relative amount of the albuminous compounds and of the saline constituents of the blood affect its flow; and, furthermore, the proportion between its organized elements and the plasm. The important influence of the nature of the organized elements, and the relative quantity in which they are present, upon the alterations in the current of the blood, is a matter directly accessible to observation, although it must be admitted that we know still very little of the character of the material changes which they produce in the anatomical constitution of the vascular ducts themselves.

Upon all the phenomena hitherto mentioned, we look from a physiological point of view. Changes and deviations from the normal, and their return, within certain limits, occur, and it is a general law of the teleological mechanism in organic nature, that the cause of changes or want, in the living organism, is, at the same time, the cause and incitement to satisfy the want; a self-regulating law in nature. But it can not be denied that the physiological conditions often fluct-

uate so near the border of pathological affections that they gradually pass over into them. They can, as such, however, only be recognized where they produce permanent changes in the structural constituents of the parts affected, palpable lesions, which require for their return to the normal state, the intervention of other agents, beyond the physiological remedial power of the organism, and either submit to the action of these, or terminate in a destruction of the histological elements involved.

There is no part of the organism which is more frequently subjected to changes, than the circulatory apparatus and of its components, the capillary system, in the highest degree. This system represents the channels for the distribution and the absorption of material, and is the means of communication between the external conditions of life and the life of the tissues in the higher organized beings. Thus it participates in all processes connected with the life actions of the different tissue elements, as well as with the specific functions of the organs, while its own function necessarily appears to be far more of a passive than of an active character. This is the more evident since the important question, whether the consumption of oxygen and the production of carbonic acid takes place in the vascular ducts by the action of oxidizable material, or in the tissues themselves, has been decided in favor of the latter view.

Nevertheless it must be admitted, that the endothelium, which builds up the capillary sheath, represents more than a simple membrane, and that in itself, it possesses properties which play a certain role in the interchange between the nutritive and the irritative constituents of the blood, and the products of the chemical processes by which the life action of the tissues is maintained. Aside, therefore, from the gen-

eral influence of the propulsive power of the heart, the condition of the capillaries is directly dependent upon: first, the pressure of the blood against their walls, originating from the constrictions and dilatations of the smaller arteries which empty into the capillary system; secondly, upon the peculiar properties of their endothelium; and, thirdly, upon the vital energy of the tissues themselves; and we may add, upon the physical character of the tissues in which they are found.

It has already been remarked in a preceding article, that, according to simple hydraulic principles, the velocity of the blood-current in the capillary system, in general, must be exceedingly slow, aside from the increase of the peripheral resistance, caused by friction, and the normal tonus of the vessels. In the capillaries of the grey cortex of the human brain, for instance, it must be about a thousand times slower than in the aorta, at its point of origin. It can not exceed the one-fiftieth part of an inch, per second, and is probably considerably slower.

Now, we must keep in mind that the arterial system, in the normal state, is at all times overfull, and that it empties its surplus, continuously, into the capillaries. The more extended and delicate the capillaries, the greater the peripheral resistance and the higher the pressure will be in the arterial system, while in the corresponding venous system the pressure is lower, and the veins less full. When, on the other hand, the resistance in the capillary system is diminished, as in a condition of general dilatation of the capillaries, there will be a rise of pressure in the veins, and a gradual fall of pressure in the arteries. Both are physiological conditions, and they may be transient and readily compensated for by a temporary increase or decrease in the action of the heart, as

well as by the action of the peripheral or the central vaso-motor apparatus in the way above indicated. By some or other influence, however, these physiological conditions may become permanent, and pass over into true pathological states, either confined to a certain organ, or affecting the whole vascular system. In the first case they will necessarily lead to alterations in the capillary system, and secondarily, to changes in the nutrition and in the function of the organ affected; in the latter case to alterations in the muscular, or in the valvular mechanism of the heart.

It can be anatomically proved that such affections, referred to in the foregoing, which stand at the border of physiological and pathological conditions, and which lead to alteration in the capillary system, frequently occur, without having at the time of their occurrence visibly interfered with the nutrition, or the function of the organ thus affected. This, for instance, is especially the case in the brain, where, on the one hand, prominently in the grey cortex, conditions exist which are most favorable for the development of locally confined affections, and where, on the other hand, as it seems, no ample provisions exist for the removal of the traces of the alterations which have taken place. I, at least, have not yet dissected one adult brain, either from persons who died accidentally in apparent health, or from persons who had suffered from brain disease previous to death, which did not contain, in the one or in the other convolution, more or less marked evidences of gross alterations in the capillary system. These were represented by the presence of remnants of capillary vessels, which, at one time or other, by causes unknown, must have been cut off from the general circulation. They are found preserved, embedded in the cerebral tissue, forming rigid shrubs, of larger diameter

than the living normal capillary, with thickened, longitudinally striated walls. At the one end they show commonly a kind of a knobby dilatation, which, at one point, runs out into a long filament, probably the collapsed sheath of the unaltered portion of a capillary vessel. Frequently, but not always, they exhibit a slightly glassy appearance, and offer a great resisting power to the influence of acids and alkalies, as well as to ether, chloroform and alcohol. They are of a cartilaginous consistence, and I have never observed any alteration of tissue in their immediate surroundings. Aside from a little granular material, occasionally met with in the tubes, they seem to be filled with a uniform, slightly refracting substance, and the only theory in regard to their origin, which I can suggest, is that they are, as indicated in the foregoing, the remnants of occluded, dilated, and finally degenerated capillary vessels, which have become infiltrated with an inorganic compound, in combination with an albuminoid, which is indifferent to the chemical processes occurring in those parts of the living organism.

It remains to state that the principal seat of this alteration of the capillaries is the grey cortex of the cerebrum; next to this they are occasionally met with in the central grey ganglia, and in the pia mater. In the white layer, in the pons Varolii, the medulla oblongata and the spinal cord they must be exceedingly rare, if they ever occur. By this, of course, I do not mean the occlusion of capillaries *per se*, but the peculiar processes which follow the occlusion, and which lead to the formations above described. In over three hundred examinations of the portions of the brain mentioned, and in twenty-one of the cord, I have never met with a single case.

This is the first material and permanent change in the vascular system of the nervous centers, to which I call attention. Although, in its origin standing at the border of physiological and pathological conditions, it presents in its results, a lesion of true pathological character. In proportion to the extent in which the lesion is found in any given case, it should be taken into consideration, as it is, at all times, an evidence of disturbance in the capillary circulation, which is of significance in an etiological point of view.

[To be Continued.]

# SARCOMA OF THE DURA MATER.

## REPORT OF A CASE, WITH ILLUSTRATIONS.

BY EDWARD N. BRUSH, M. D.,
Assistant Physician, New York State Lunatic Asylum.

The following case is here reported, both on account of its clinical and pathological significance. In March, 1875, I was invited by my friend, Dr. E. C. W. O'Brien, of Buffalo, to see Mr. S———, who had sought advice concerning a tumor situated just anterior to the junction of the saggital and lambdoid sutures. The patient was a gentleman aged fifty-six, of clear, ruddy complexion, large frame and somewhat inclined to obesity. For some years he had been occupied as librarian in a large public library, but had recently assumed charge of some mining interests. The tumor was about the size of a small walnut. It was quite movable under the scalp, and pretty firm pressure and free handling gave rise to no indications of pain or uneasiness. Its growth had been slow and unattended by pain. From these facts, and from the presence of what was apparently a similar growth, though of several years' standing at the outer and upper margin of the left orbit, an ordinary sebaceous tumor of the scalp was diagnosed, and its removal suggested. Not being able at the time to leave his business, the patient preferred to postpone the operation until he could take a short vacation in the summer. I saw nothing more of him until February 13, 1876, when I was requested to assist in the removal of the tumor, which I then found had increased rapidly in size, and was therefore somewhat inconvenient. I was quite surprised on carefully examining the patient, at the size and shape which the

tumor had attained. It measured about four and one-half inches in one diameter, by about six in the other, and projected from the cranium some three inches at the most prominent point. The tumor was covered by the dense, shining scalp; was irregularly nodulated, and but slightly movable. The slight mobility was accounted for by the extreme tension of the scalp. The tumor was not painful on pressure, and the patient allowed pretty free manipulation without complaint; it did not pulsate, was soft and somewhat elastic. Some portions of the exterior were red and vascular, and attracted attention and comment.

After due consideration it was decided to attempt to remove the tumor, and to proceed as far as possible by enucleation, after the first incision. Anæsthesia, with ether, being induced, an incision was made from before backwards, over the most prominent part of the tumor. Attention was at once attracted to the unexpected thickness and great vascularity of the scalp. The tissues through which the knife passed were dense, and the vessels much enlarged. When exposed, the tumor showed what was apparently a containing sac or cyst-wall. I at once passed my finger into the wound, and commenced the process of enucleation. The growth was easily separated from the scalp, but I was surprised on approaching its base to find that my finger did not pass under it and come in contact with the cranium, but seemed to follow out the covering membrane, which apparently spread out in all directions upon the skull, and made it impossible to raise the tumor from its attachments. Thinking that I might possibly have mistaken a layer of fascia for the investing membrane of the tumor, this was ruptured with the nail, and the finger passed immediately down upon the cranium and thence under

the tumor. I at once recognized the fact that the finger had passed into the substance of the growth; that it was not sebaceous, and that beyond the membrane just ruptured, it had no retaining sac. Using the finger as a director the incision was enlarged in order that the tumor might be more easily examined, and the extent of its attachments determined. This done I passed my finger through the opening already made in the apparent covering of the tumor, down to its base. In doing so it came in contact with roughened and denuded bone, and in sweeping the finger under the growth to separate it from the skull I was startled by passing it into an opening in the cranium. A brief examination satisfied all present that the tumor either had its origin from, or passed into the cranial cavity, and it was decided to discontinue the attempt at removal, Before closing the incision, Prof. J. F. Miner was called in consultation. After a careful examination he expressed the opinion that the growth originated within the cranium, that it had eroded its way through the cranial walls, and that its removal was impossible. The incision was loosely drawn together, warm water dressings applied and the patient placed in bed.

On recovering from the ether the patient's mind was clear and active, pulse one hundred, respiration unimpeded, and he complained of but little pain. A portion of the incision healed by first intention, but the extensive separation of the attachments of the tumor, which had been made with the finger, destroyed its vitality, and in a few days, I was able to lift out a large portion of its most prominent part. After the removal of a few remaining shreds by suppurative process, a red protuberant mass, about the size of a walnut, was noticed at the bottom of the cavity; this mass bled easily and pulsated regularly. The pulse

never rose above one hundred and twenty, and frequently was as low as eighty. The discharge from the wound was profuse, and at times quite offensive. No chill or febrile stage was at any time observed. For four weeks the patient remained in this comfortable condition. Motion and sensation were at all times normal, and he continued to direct his business affairs as clearly as ever, and carefully arranged matters in view of his probable death.

On the morning of March 8th, Mr. S. noticed a loss of power and sensation of the right side. This condition gradually increased until it reached almost complete hemiplegia. The eyes were suffused, pupils contracted, face red, pulse rapid and bounding, temperature 103°. He complained of intense headache, was easily disturbed and restless when asleep, but at no time delirious, motion and sensation gradually returned, and on the thirteenth, were nearly normal. The headache was relieved by bromide of potassium, and the temperature controlled by quinia. From the tenth to the time of the death, the catheter had to be resorted to, to evacuate the bladder. On the twentieth, there was nearly complete *left* hemiplegia. At midnight on March 22d, I saw the patient, being hastily summoned in the absence of his attending physician, Dr. O'Brien. He was in a semi-comatose condition, respiration stertorous—twelve per minute: pulse, rapid and feeble. He could only be aroused with considerable effort, but would then make intelligent replies to questions. The coma increased steadily, and terminated in death in the forenoon of the twenty-third.

Autopsy.—The tumor projected from the upper back part of the head in the median line. Its base had a diameter of some six inches, and it projected about

three inches above the skull. In its center was a crater-like excavation, two inches in diameter, extending down to bone. Its edges were ragged, red and granulating, the sides grayish and sloughing. The weight of the tumor was estimated at one and one-half pounds. On section the pericranium was found to be elevated by the tumor. The scalp, though thickened, was separable from the morbid growth on all sides. On separating the tumor from the skull, the central portion of its base was found continuous with an inter cranial portion, through an irregular, ragged erosion in the cranial walls, with a diameter of from one and one-half to two inches. The eroding process had affected the border of the perforation for a circle of half to three-quarters of an inch breadth about it. This erosion is shown in Fig. one, representing the outer surface of the calvarium.

FIG. I.

Other portions of the bone covered by the tumor were more or less roughened. The inner surface of the calvarium showed the channels for meningeal vessels

deeper than common. The margin of the opening was rough and irregular, and its edges bevelled by the eroding process, as shown in Fig. two, showing that the tumor was originally wholly inter-cranial.

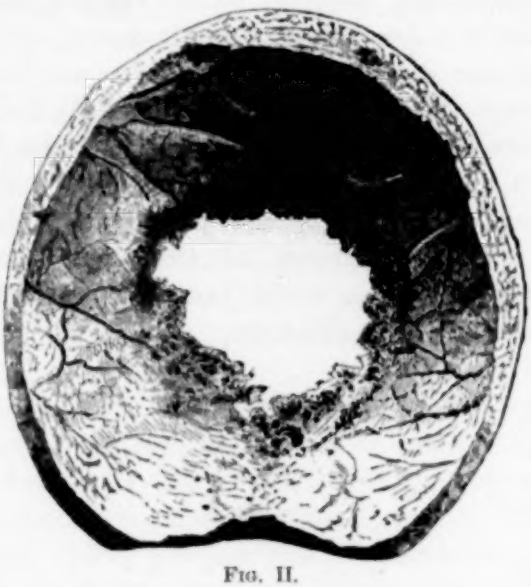

Fig. II.

The dura mater was thickened, non adherent; pia injected. The tumor arose in the falx cerebri, extending between the hemispheres for the depth of an inch and one-half. The portion internal to the skull weighed four ounces. The convolutions on either side of the median line were flattened by pressure, and marked depression was observed in the lobes of either hemisphere where the tumor had lain. They were, however, not involved in the new growth. On incision, an abscess, the size of a pigeon's egg, was found in the left posterior central convolutions. The brain was not subjected to microscopic examination. Sections of the tumor, placed under the microscope, showed it to be round celled sarcoma. The interesting features of this

case are the size and origin of the tumor, and the absence of all brain disturbance, until a short time prior to death, due probably to the early relief of pressure by perforation of the cranial vault. Growths of this character are recorded under various names, as fungus hæmatodes, fungus duræ matris, malignant tumor of the dura mater, etc. Gross mentions two operations for the removal of similar tumors, and Erichsen and Hamilton mention operative procedure as the last resort, advising enlargement of the cranial aperture, and careful dissection of the tumor from the dura mater. It hardly seems to me, that a full knowledge of the parts involved, would justify an attempt to remove a tumor of this character.

# BIBLIOGRAPHICAL.

## REVIEW OF AMERICAN ASYLUM REPORTS, 1878–79.

NEW HAMPSHIRE:

*Report of the New Hampshire Asylum for the Insane:* 1879. Dr. J. P. BANCROFT.

There were in the Asylum, at date of last report, 276 patients. Admitted since, 73. Total, 349. Discharged recovered, 27. Improved, 23. Unimproved, 8. Died, 23. Total, 81. Remaining under treatment, 268.

Owing to a change in the fiscal year of the Asylum, the report covers a period of eleven months only. Of the admissions fifty-six per cent were chronic cases. It appears that only thirty-four per cent of all the cases under care during the year could be classed as curable, while sixty-six per cent must be regarded as past all reasonable hope of recovery. Of the twenty-seven recoveries eleven were from first attacks, and sixteen had suffered from one or more attacks. In view of this fact the Doctor comments upon the effect of habit, in producing a tendency to the recurrence of the disease, and upon the necessity of studiously avoiding every act and influence calling into activity morbid states. Another noticeable fact in recurrent insanity is the reproduction of the same features in the various attacks.

The number of cases of aged persons admitted, leads to the advice that, whenever practicable, such persons should be retained at home, and not subjected to the often injurious influence of breaking off the associations and surroundings there, for the new objects and

change of habits incident to life in an asylum. A record of improvements and renovation of wards, necessitated by long use, with a statement of projected changes, closes the report.

MASSACHUSETTS:

*Twenty-Sixth Annual Report of the State Lunatic Hospital, at Taunton:* 1879. Dr. J. P. BROWN.

There were in the Hospital, at date of last report, 579 patients. Admitted since, 173. Total, 752. Discharged recovered, 48. Improved, 73. Unimproved, 24. Died, 48. Total, 193. Remaining under treatment, 559.

Considerable attention has been paid to inducing patients to take exercise in the open air, and to labor upon the farm and grounds. The improvements in the buildings heretofore inaugurated have been carried forward towards completion.

*Second Annual Report of the State Lunatic Hospital, at Danvers:* 1879. Dr. CALVIN S. MAY.

There were in the Hospital, at date of last report, 222 patients. Admitted since, 653. Total, 875. Discharged recovered, 115. Improved, 72. Unimproved, 92. Died, 63. Total, 342. Remaining under treatment, 533.

The subject of causation receives prominent attention in the report. The want of regular and systematic occupation is first mentioned as a cause, and is denominated "a *fons et origo*, as well as a continuance of the disease, oftener than we are apt to think." "Large numbers of the insane are so because they lack systematic and regular occupation of mind and body. Indeed, I think they would outnumber four to one the cases where disease was the result of overwork." "Much

has been said of the overworked activity of Americans, as a permanent cause of the increase of mental disease. My observation teaches me this is incorrect." "The more I watch for immediate causes of mental perturbation, the more convinced I become that the indulgence of excesses connected with the appetite must be responsible for a large number of cases. The uneasy organization seizes often upon alcoholics as being frequently suggested as something discountenanced; the gratification of dealing with a contraband thing leads to an excess just as surely, and in the same proportion as the nervous unrest exists. A better morality will bring a better organization, inasmuch as the habits of thought upon life as a responsibility to be used for other than sensual enjoyment, leads to a restfulness of mind, and reliance upon something outside the physical condition and appetites."

It is not surprising that, with these views of causation, the Doctor should look upon employment as the panacea for the disease, and that no mention should be made of the more strictly medical treatment of insanity. The report of the pathologist, Dr. J. J. Putnam, of Boston, gives six post mortems as having been made during the year. In these the causes of death are detailed, and in two of them only is any note made of the condition of the brain. The subject of disposition of the sewage has received considerable attention, and the mode adopted is pronounced a success.

*Twenty-fourth Report of the State Lunatic Asylum, at Northampton:* 1879. Dr. PLINY EARLE.

There were in the Hospital, at date of last report, 429 patients. Admitted since, 106. Total, 535. Discharged recovered, 26. Improved, 28. Unimproved, 14. Sober, 1. Not insane, 1. Died, 23. Total, 93. Remaining under treatment, 442.

The finances are represented as being in a favorable condition. The Doctor continues to discuss the subject of the "Curability of Insanity." He shows the deceptive character of the statistical tables formerly presented, in asylum reports, to show the advantage of early treatment, both in an economic point of view, and in the larger percentage of recoveries. His conclusion confirms the result reached by Dr. Thurnam in his statistics of insanity, that "of ten persons attacked by insanity, five recover, and five die sooner or later during the attack; of the five who recover, not more than two remain well during the rest of their lives; the other three sustain subsequent attacks, during which at least two of them die."

*Report of the Temporary Asylum for the Chronic Insane, at Worcester:* 1879. Dr. H. M. Quimby.

There were in the Asylum, at date of last report, 375 patients. Admitted since, 47. Total, 422. Discharged improved, 7. Unimproved, 11. Died, 33. Total, 51. Remaining under treatment, 371.

The quantity and quality of the dietary, and also the proportionate number of attendants, are said to remain the same as when occupied by all classes of the insane, under the name of the State Lunatic Hospital. The proportion of attendants is one to every thirteen patients.

*Forty-seventh Report of the State Lunatic Hospital, at Worcester:* 1879. Dr. John G. Park.

There were in the Hospital, at date of last report, 509 patients. Admitted since, 147. Total, 656. Discharged recovered, 47. Improved, 45. Unimproved, 37. Not insane, 1. Died, 36. Total, 166. Remaining under treatment, 490.

The report is largely devoted to an account of the mode of utilizing the sewage adopted. This is represented by heliotype prints, and is pronounced a success by the authorities of the Hospital.

CONNECTICUT:

*Report of the Connecticut Hospital for the Insane:* 1879. Dr. A. M. SHEW.

There were in the Hospital, at date of last report, 481 patients. Admitted since, 163. Total, 644. Discharged recovered, 45. Improved, 33. Unimproved, 37. Died, 19. Total, 134. Remaining under treatment, 510.

The health of the patients has been good, and the number of deaths remarkably small. Of the nineteen, five were from general paralysis, and four from the decay of age, all of the latter being over seventy-eight years.

The Doctor urges upon the attention of the Legislature, the propriety of erecting a group of buildings for the quiet, harmless insane, in connection with the present Hospital. This plan was approved and recommended in the report of the commission appointed to consider the subject. The building proposed, was intended to accommodate 250 patients, and could have been contracted for, for $120,000. This question of the care of the insane, naturally led to a consideration of the care and treatment of this unfortunate class in earlier times, and a comparison with the methods employed at the present day. A condensed history of insanity is presented, and the gradual growth of the present style of hospitals, and methods of administration.

The list of entertainments shows a diversity well adapted to instruct and amuse the listeners. Military exercises and drill are still kept up, and much proficiency

attained by the patients. Among the improvements reported, is the completion of the annex, used for the more disturbed class of women patients, and a new reservoir of some three acres, and a capacity of four and one-half millions of gallons.

NEW YORK:

*Report of the New York City Asylum for Insane, Ward's Island:* 1878. DR. A. E. MACDONALD.

There were in the Asylum, at date of last report, 776 patients. Admitted since, 467. Total, 1,243. Discharged recovered, 38. Improved, 64. Unimproved, 26. Died, 126. Total, 254. Remaining under treatment, 989.

Dr. Macdonald reports steady progress in increasing the comforts of the patients—in the matter of food and clothing especially, the improvement in both quality and quantity being marked. The staff of attendants has been increased to seventy-four against forty-nine at the beginning of the year, thirteen doing night duty alone. Wages have been raised, and the efficiency of the staff multiplied. Overcrowding is still complained of, the buildings erected for 434 patients being occupied by 689. The office of Assistant Medical Superintendent has been created, and the staff of physicians connected with the asylum now numbers seven. The question of removal of the asylum to Long Island is quite fully discussed, and the reasons against such change presented at some length. The experiment of opening the wards of the Asylum for clinical instruction is reported to be a success, and the lectures given by the Superintendent have been continued.

*Report of New York City Lunatic Asylum, Blackwells Island:* 1878. Dr. W. W. Strew.

There were in the Asylum, at date of last report, 1,367. Admitted since, 430. Total, 1,797. Discharged recovered, 155. Improved, 49. Unimproved, 26. Improper subjects, 5. Died, 95. Transferred, 233. Total, 563. Remaining under treatment, 1,234.

The excess of patients over the capacity of the Asylum is 370. Much has been done during the year to improve the condition, and enlarge the capacity of the various buildings constituting the Asylum.

The number of attendants has been increased, and the dietary improved in quantity and quality. The question of restraint is discussed: the use of it is said to have been largely diminished, and such restrictions imposed as to render its unauthorized employment impossible. Passes have been granted to an average during the year of thirty-one patients, and the system is commended. A strong plea is made for some provision to give assistance to such of the friendless and penniless as recover, to enable them to support themselves till they can find employment. This field for philanthropic benevolence has been almost entirely overlooked. One person, however, has, during the year succeeded in placing several women patients, discharged recovered, from the Asylum, in places where they have, by their good behavior, repaid the kindness shown them. If the municipal institutions would adopt the policy of the State, no persons could be sent out in such a penniless condition. The law provides, see Sec. 26, Title 3, Chap. 446, Laws of 1874.

"No patient shall be discharged without suitable clothing, * * * also money, not exceeding twenty dollars, to defray his necessary expenses until he reaches his friends, or can find a chance to earn his subsistence."

PENNSYLVANIA:

*Report of State Lunatic Hospital, Harrisburg:* 1879. Dr. JOHN CURWEN.

There were in the Hospital, at date of last report, 426 patients. Admitted since, 147. Total, 573. Discharged recovered, 29. Improved, 31. Unimproved, 58. Died, 29. Total, 147. Remaining under treatment, 426.

*Report of the Western Pennsylvania Hospital for the Insane, Dixmont:* 1878. Dr. JOSEPH A. REED.

There were in the Hospital, at date of last report, 543 patients. Admitted since, 239. Total, 782. Discharged recovered, 63. Improved, 49. Unimproved, 29. Died, 42. Total, 183. Remaining under treatment, 599.

Owing to the non-completion of the new State Asylum, at Warren, this Institution is greatly overcrowded, as it contains two hundred patients more than its proper capacity. While speaking of the disuse of the airing courts in foreign asylums, the statement is made that none have existed in connection with this Hospital during the past sixteen years. Within the buildings repairs and improvements have been kept up. Walls and ceilings have been painted and frescoed, new furniture and carpets have been supplied as needed, and the previous standard of care has been fully met. Few changes have been made in the grounds or outside surroundings, for lack of an appropriation, which had been asked from the State.

VIRGINIA:

*Report of the Eastern Lunatic Asylum of Virginia:* 1879. Dr. HARVEY BLACK.

There were in the Asylum, at date of last report, 316 patients. Admitted since, 51. Total, 367. Dis-

charged recovered, 26. Improved, 1. Died, 17. Total, 44. Remaining under treatment, 323.

There were 198 applications for the admission of patients to the Asylum. Of this number 122 were necessarily rejected for want of room. The outlook is, however, more gratifying, as additional accommodations are being prepared in buildings which will soon be completed, at this and the Western Virginia Asylum, for 210 patients. Much inconvenience has been experienced from the decrease in the appropriation from the State, and still further from the neglect to pay the whole amount appropriated. A new water supply, sufficient for all the needs of the Asylum, has been provided, at an expense of some $6,000. The Doctor urges the propriety of some provision by the State for pecuniary assistance, sufficient to pay, in whole or in part, for the support of certain of the chronic class, outside of the Asylum, among their friends, who may be unable to meet the expense of their maintenance. The use of alcohol as a cause of insanity, and its effect in producing neurotic disease in the individual, or in succeeding generations, is discussed at some length.

*Report of the Central Lunatic Asylum of Virginia, (for Colored Insane):* 1878–79. Dr. Randolph Barksdale.

There were in the Asylum, at date of last report, 244 patients. Admitted since, 33. Total, 277. Discharged recovered, 34. Improved, 2. Died, 18. Total, 54. Remaining under treatment, 223.

This Institution has also been crippled from the reduction in the annual appropriation for the support of patients, and from the non-payment of the sum appropriated. By the aid of an unexpended balance of previous years, the actual indebtedness of the Asylum is only $166.25 The policy of erecting additional wards to

receive all of the colored insane of the State from the jails, when they can be supported at less than half the present cost, is strongly urged. It is calculated that this would result in a saving of $10,000 for the first year, and $18,000 for the subsequent four years., the period for which the State has a lease of the grounds and buildings now occupied.

*Report of the Western Lunatic Asylum of Virginia:* 1879.

There were in the Asylum, at date of last report, 423 patients. Admitted since, 109. Total, 532. Discharged recovered, 43. Improved, 10. Unimproved, 4. Eloped, 1. Died, 26. Total, 84. Remaining under treatment, 448.

The report announces the death of Dr. R. F. Baldwin, the Superintendent, which took place on the 14th of November, 1879, after a protracted illness. "A man of ability and administrative tact, he united to the highest factors of a true manhood the gentleness and graces of a woman, rounded out into the highest type of the Christian gentleman." A short and condensed report of the workings of the Institution is presented by the Assistant Physicians, Drs. Hamilton and Fisher.

South Carolina:

*Fifty-Sixth Report of the South Carolina Lunatic Asylum:* 1879. Dr. P. E. Griffin.

There were in the Asylum, at date of last report, 331 patients. Admitted since, 162. Total, 493. Discharged recovered, 40. Improved, 4. Unimproved, 1. Escaped, 3. On trial, 9. Died, 61. Total, 118. Remaining under treatment, 375.

The most notable event of the year is the rapid increase of the population. There are forty-four more patients under treatment than at the same time last year. The question of future provision is prominently

forced upon the attention. An appropriation of $5,000, made by the last Legislature, is still intact, and some material in brick and granite has been collected toward additional buildings. Some improvements have been made from current funds, and the financial condition is reported as favorable.

GEORGIA:

*Report of the Lunatic Asylum of the State of Georgia:* 1879. Dr. T. O. POWELL.

There were in the Asylum, at date of last report, 742 patients. Admitted since, 209. Total, 951. Discharged recovered, 64. Improved, 28. Unimproved, 7. Eloped, 8. Died, 90. Total, 197. Remaining under treatment, 754.

The report of both the managers and Superintendent record the death of Dr. Thomas F. Green, for more than thirty-three years the Superintendent and Resident Physician to the Asylum. He died on the 11th of February, 1879, suddenly, from apoplexy, at the advanced age of seventy-four years. When he assumed charge of the Asylum there were but sixty patients in its fostering care. In the present large and flourishing charity he has left a fitting monument to the labors of a life devoted to the care and relief of the sick and unfortunate. The record of the improvements to the buildings, and the additions to the means of moral treatment, show considerable progress made during the year.

LOUISIANA:

*Report of the Insane Asylum of the State of Louisiana:* 1879. Dr. J. W. JONES.

There were in the Asylum, at date of last report, 198 patients. Admitted since, 50. Total, 248. Dis-

charged recovered, 11. Died, 27. Total, 38. Remaining under treatment, 210.

The Institution labors under serious disadvantages. There is a lack of proper means of heating, and of lighting; of machinery in the laundry for washing and ironing; of means of amusement and entertainment; and the buildings are sadly out of repair. The number of attendants is entirely inadequate, there being one to every twenty-five patients, and no night watchers are employed. The wards are overcrowded, and so limited in number that an attempt at classification is almost impossible. For the erection of additional buildings, to carry out the original plan, 225,000 bricks were made during the year by the patients and employees, at a cost of less than two dollars per thousand. An appropriation is asked from the Legislature of $20,000, for two years, for the cost of new buildings. The demands for admissions, which could not be met, has resulted in the detention of many patients in the jails and in the City Asylum, in New Orleans, which has been felt as a source of great local distress and inconvenience.

KENTUCKY:

*Report of the Eastern Kentucky Lunatic Asylum, Lexington:* 1879. Dr. R. C. CHENAULT.

There were in the Asylum, at date of last report, 531 patients. Admitted since, 151. Total, 682. Discharged recovered, 52. Under Laws 1876–78, 16. Removed, 13. Transferred, 12. Died, 38. Escaped, 2. Total, 133. Remaining under treatment, 549.

The report gives a long list of improvements made during the year, and of wants to be supplied in the future. A recommendation is made for the erection of a system of cottages, supplemental to the present Asy-

lum, at about one-third of the per capita cost, for the care of the chronic class of patients.

OHIO:

*Report of the Longview Asylum:* 1879. Dr. C. A. MILLER.

There were in the Asylum, at date of last report, 660 patients. Admitted since, 178. Total, 838. Discharged recovered, 57. Improved, 21. Unimproved, 17. Eloped, 2. Died, 55. Not insane, 3. Total, 155. Remaining under treatment, 683.

*Report of the Columbus Asylum for the Insane:* 1879. Dr. L. FIRESTONE.

There were in the Asylum, at date of last report, 850 patients. Admitted since, 364. Total, 1,236. Discharged recovered, 214. Improved, 45. Unimproved, 82. Not insane, 9. Died, 54. Eloped, 2. Total, 406. Remaining under treatment, 830.

Dr. Firestone has written a report of some forty-five pages, in which he has touched upon a great variety of topics, among them the care of epileptics, insane convicts, causation, heredity, existing causes, autopsies, treatment of the insane, chapel services, amusements, bequests. These are followed by the ordinary statistical matter, by the record of improvements and repairs, and of wants. From the last list there would seem to be much work to be done before the Institution can be said to be completed.

MISSOURI:

*Report of the St. Louis Insane Asylum:* 1878–79. Dr. N. DE V. HOWARD.

There were in the Asylum, at date of last report, 308 patients. Admitted since, 188. Total, 496. Discharged recovered, 35. Improved, 25. Unimproved, 22. Sober, 3. Eloped, 1. Not insane, 2. Died, 16, Transferred, 70. Total, 174. Remaining under treatment, 322.

WISCONSIN:

*Report of the Northern Hospital for the Insane:* 1879. Dr. WALTER KEMPSTER.

There were in the Asylum, at date of last report, 559 patients. Admitted since, 198. Total, 757. Discharged recovered, 65. Improved, 68. Unimproved, 43. Died, 35. Total, 211. Remaining under treatment, 546.

We quote from the remarks on causation, in which the generally received views are plainly and succinctly stated.

> To resolve the tangled web of causation and determine what item is harmful and what item harmless to mental health, is a task that only infinitude can comprehend. It is impossible, under the most favorable states, to separate into elementary parts, all the minute circumstances leading up to a final change from a sane to an insane state; it is, indeed, often difficult to draw the line between these two conditions, and to say where one ends and the other begins, so subtle are the beginnings. It is not often that one grand catastrophe overtops mental health; it is the constant recurrence of unfavorable acts or thoughts, the steady disregard of healthful conditions, the accumulation of adverse surroundings which from selection or misfortune heap themselves upon the individual; the oft repeated disregard of the common laws of hygiene, ignoring temperance in all things, deviating from established principles either in thought or morals; in fact, any or all things which tend to lower vitality and produce disease, operate as a cause. Now, it is impossible to separate out from all the rest one factor which would be more likely to produce disease than its congeners, and if we could do so it would not affect the result. Each individual organism has its own peculiarities, its own weaknesses, and what might seriously retard healthy growth in the brain tissue of one person, might not so seriously affect the same tissue in another.

As in previous reports Dr. Kempster has treated of heredity and of education. The neglect on the part of educators to inculcate sound physiological principles, is considered a fruitful cause of the production of mental disturbance. In speaking of the importance of this kind of education, he says:

I would have everyone to know that health is paramount; that disease and degeneration may be avoided by adherence to a few simple hygienic rules; that it is courted when the rules are ignored. I would have them to know how to interpret nature's language; to know the law of their own being, and how to apply it to their environment. I would have them know that nature has fixed bounds which may not be overstepped; in short, I would have a multiplication table of health, which should be as sedulously instilled into the mind of a child as is its mathematical symbol; then we should have fewer doctors, fewer asylums for the mentally inferior, fewer criminals, and a higher, better, loftier, healthier people to battle with the problems of life. Let us have sound bodies, and we shall, in the main, have sound minds.

A system of education that falls short of instructing people how to develop the mental faculties in the proper order—neither over-feeding or starving them—and how best to maintain them in a state of health when developed, does not fulfill all the requirements, and leaves the individual in profound ignorance of those things which materially affect his own welfare and the welfare of society. The influence of the body upon the functions of the mind is conceded, but the concession has been wrung out of a bitter experience, bought at a price that the world can ill afford to pay.

Many very marked examples of the hereditary tendency to insanity are given, as having occurred among the patients admitted to the Asylum. These extend, in some cases, through several generations, and by their frequency, show how thoroughly the family stock is permeated with hereditary influences.

Improvements have been made during the year in the erection of a new laundry and wash-house, also of a new barn and vegetable cellar. The artesian well which has thus far furnished the water for ordinary purposes, is entirely inadequate in case of fire. A plan to obtain water from the lake is proposed for consideration of the Legislature. The financial affairs of the Institution are in a favorable condition, the current receipts being sufficient to meet all demands.

## BOOK NOTICES.

*The Brain and its Diseases.* Part I. Syphilis of the Brain and Spinal Cord. Showing the part which this agent plays in the production of Paralysis, Epilepsy, Insanity, Headache, Neuralgia, Hysteria, Hypochondriasis, and other Mental and Nervous Derangements. By THOMAS STRETCH DOWSE, M. D., etc. New York: G. P. Putnam's Sons, 1879.

Syphilis of the nervous system remains, notwithstanding the labors of Lanceraux, Gros, Zambaco, Jacsch, and later, Broadbent, Hughlings Jackson, Buzzard, Heubner and others, one of the most promising fields for medical investigation and scientific classification. To this fact, doubtless, we owe the appearance of the work now before us, but we are sorry to say that it has added but little to the accurate and readable literature of the subject.

Dr. Dowse has divided his volume into eight chapters. The first of these treats of the "History and Nature of Syphilis." Concerning the history of syphilis he has little to say, contenting himself with a brief recital of the literary chronology of the subject. Of the nature of syphilis the author writes more extensively, and with more positiveness. His statements as to symptomatology and etiology are not such as will be readily accepted, and lack confirmation from experienced syphilographers. Concerning the initial lesion, Dr. Dowse declares that constitutional symptoms follow indifferently the hard and soft sore. While we are willing to admit that constitutional infection sometimes follows an apparently soft chancre, we think that the majority of careful observers will bear us out in the statement that this is the exception, and that the infec-

tion is to be explained by the supposition of a "mixed sore." The mooted question of unity and duality is yet to receive scientific decision. It may be decided that all venereal sores are of syphilitic origin, and thus establish the tenets of the unicists. But, admitting that soft chancre is in some way modified syphilis, there is certainly a duality in the kind of sores produced, and upon this the whole question turns. Dr. Dowse will find, if he observes carefully, that soft chancres, the chancroid of Clerc, appear with no appreciable period of incubation. The unmodified infecting chancre always has a period of incubation averaging some three weeks. The inocculation from the soft chancre, unmixed with syphilitic virus, is *never* followed by syphilis. Inocculation from the hard chancre, or, if the term hard is objected to, from the chancre borne by a person syphilitic at the time, and having a period of incubation is always followed by constitutional symptoms. The differences between the two sores has been compared to the differences between variola and varioloid, but no such analogy exists. Varioloid is capable of giving rise to variola; chancroid, or the soft chancre, never gives rise to syphilis, unless along with its virus, and hidden by the intensity of its local action has been implanted the syphilitic virus. This chapter is written with evident haste, and is marred by several inaccuracies and grammatical errors. For instance, in speaking of certain visceral changes appearing during the secondary stage of syphilis, he says: "If, at this time, we have pulmonary hæmorrhages and pneumonia —not so uncommon—I think we are justified in assuming that the *origo mali* is syphilis, the more especially as mercury rapidly cures *it*." The chapter is illustrated by a Woodbury-type of what is said to be syphilis of the rectum. As far as the picture shows anything, it

might as well illustrate any other pathological change of any organ. Dr. Dowse lays considerable stress—more, we think, than it will bear upon the importance of thickening and induration of the walls of the rectum as a diagnostic sign.

In the chapter upon Diagnosis the author summarizes, (p. 16), the conclusion reached in writing upon the pathology of syphilis, but by a strange method of arrangement this subject is not treated until the last chapter in the book, so that the reader is presented with the writer's conclusions before reading his argument. "There are two prime factors," he says, "which tend to induce syphilis to expend itself upon the brain and nervous system." The first of these is "an unstable condition of these parts from hereditary predisposition." "The second is due to an instability which is the result of previous inflammatory change, (either idiopathic or traumatic in its origin), or from molescular (molecular?) derangement, followed by want of due selective nutritive capacity in the nerve or connective tissue cells, by which their tonicity is impaired." In the same paragraph the author makes the somewhat positive statement, italics his own: "*I have clearly traced a cerebral syphilis where the exciting cause has been venereal excesses, over-study, mental anxiety, worry, and even fright.*" Dr. Dowse illustrates his remarks in this chapter by typical cases, and, with a few defects in expression, and some illogical conclusions, has given quite an instructive chapter upon diagnosis.

The chapter upon Syphilis of the Sympathetic Nervous System comprises but five pages, and presents nothing new or of value. The same may be said of the chapter upon Diseases of the Peripheral Nerves and Neuralgias, which occupies six pages. Following this is chapter five, upon Treatment. The remarks here

made are evidently based upon practical experience, but there is nothing novel in the advice given. The author deprecates the routine employment of mercury and iodide of potassium. His views in regard to treatment may be summarized: Support and sustain the patient, treat special symptoms that arise, and direct active treatment toward eradicating the syphilitic virus.

Following the chapter upon Treatment are chapters upon Hereditary Syphilis and upon Syphilitic Epilepsy. While both of these chapters are better written than the balance of the work, they each show evidence of careless composition and hasty generalization. Of epilepsy the author says: "I should hold that primary idiopathic epilepsies are more due to hereditary syphilis than they are to any other cause;" a statement which will not seem surprising when it is borne in mind that, of ten thousand patients under his care during seven years at the Central London Sick Asylum, the author says: "I have no hesitation in saying that three-fourths were more or less the subjects of acquired or hereditary syphilis." This chapter is marred by the introduction of wholly extraneous remarks, written in a grandiloquent style. For example, on page 88, the author writes, immediately after discussing the pathology of epilepsy: "What a discovery, says one, so-and-so has made; he has found out that there is force in a ray of light; that the rheophore of a battery, applied to definite parts of the brain, will cause a monkey to blink, wink or squint; to dance, hop, skip or jump; to phonate a falsetto or contralto; that a decapitated frog will swim with its head upon its back, under certain stimulus—that the movements of the heart are controlled by the pneumogastric nerve, and that certain mental aberrations, known as melancholia, dementia,

delusions, illusions, and so on, can be engendered at will by those drugs which determine vaso-motor action. What advances science is making! Quite so. The wars, even of the elements, must soon succumb to the control of man, and nothing will remain for him to do but devise means whereby he can walk upon the seas, float in the atmosphere, and propel himself at will a hundred miles an hour. And even were all this realized, where would man be? Just as far from the end as ever." In another place the author tells us that, "in fact, the scientific mind has, of late years, been swamped with psycho-physiological evidence of the functions of the brain and nervous system, which, although considered tenable to-day, are to-morrow scattered far and wide, leaving a barren but still fertile soil for new hypotheses and investigations."

The concluding chapter of the work is upon Pathology, but with an inconsistency which characterizes the entire work, and which is well illustrated in the order in which the chapters are arranged, the author wanders frequently from his subject, introducing, among other matters, "a few remarks upon the clinical aspects of aphasia." But even here he wanders from his subject, leaving the clinical to discuss the legal status of the aphasic subject, and telling when he is not a responsible being. Of over one thousand post mortem examinations the author remarks that he has been surprised to find in how small a number the disease "appeared to originate in the under layer of the periosteum of the endocranium." We are utterly at a loss to comprehend the meaning of the following remarks upon case XXV, page 108: "For instance, we had hyperæsthesia of the limbs, with marked functional automatic activity of the spinal cord, arising, doubtless, from congestion of the grey matter and antero-lateral columns. The grey mat-

ter, as it became invaded, so became functionally diseased, and we had transitory and migratory impairment of sensibility, sensation, and temperature. The posterior grey matter and columns were unhealthy, and to this may be attributed the perfect power of co-ordination. But, considering the amount of disease in the periphery of the anterior horns of the grey matter, one would have expected an equivalent of muscular atrophy; but this was not the case, owing, in all probability, to the unstable dynamic condition of the grey matter of the cord generally." Dr. Dowse asserts that syphilis is "the cause of at least two-thirds of the general paralysis leading to dementia we meet with in this country, (England)." He does not evidently—and in this the cases reported by the author sustain us—recognize any difference between dementia paralytica, due to syphilis, and to which Foville, in a recent article, has applied the term pseudo-paresis, and true paresis the so-called general paralysis of the insane.

There are in this little work many good things, but they are hidden under a mass of faulty construction and illogical reasoning. There are many proof errors, and the illustrations serve, in most instances, to do anything but illustrate the text. We hope that succeeding parts of this work, when published, will be written with greater care.

*Transactions of the American Medical Association:* Vol. XXX.

This volume, which is one of the largest published by the Association, contains the proceedings of that body, at the meeting held at Atlanta, Ga., May 6th, 7th, 8th and 9th, 1879.

Following the minutes of the meeting is the address of the President, Dr. Theophilus Parvin, of Indianapolis. Dr. Parvin speaks with his usual elegance of

style, and presents an address worthy the Association and the author. Next in order to the President's address are the minutes of the Section on Practical Medicine, Materia Medica and Physiology, and the address of the chairman of the section, Prof. Thomas F. Rochester, M. D., of Buffalo, N. Y. In this address Dr. Rochester, after discussing the subjects of epidemic pestilential diseases, and their prevention, including quarantine, takes up the advances which had been made during the year in materia medica and physiology, and presents a concise and valuable resumé of these topics. The papers read before the section were all of interest and some of practical importance.

The address on Obstetrics and Diseases of Women and Children, was delivered by Dr. E. S. Lewis, of New Orleans, La. Dr. Lewis opens his address by a reference to the employment of *Abdominal Palpation* in obstetric diagnosis, and in the correction of malposition of the fœtus, a procedure recently recalled to the notice of the profession by Dr. Pinard, (*Annales de Gynécologie*, December, 1878). This is not a new diagnostic or operative measure, having been presented to the profession by various writers, under different terms, as external version, diagnosis by manipulation, etc., and its claims urged with more or less persistency. Following this the speaker alludes to the *Antiseptic Management of Labor*, and next in order, to *Puerperal Fever*, a subject which derives much interest when taken in consideration with the preceding Following these, which are the more interesting topics considered in the address, Dr. Lewis passes in review the advances in obstetrics and gynæcology made during the year. In the proceedings of this section Dr. Battey has an interesting report of a case of *Tubo-ovarian pregnancy*, with operation, followed by death. Dr. Cutter gives the

results of *Electrolysis of Uterine Fibroids*, but little of importance is to be gleaned from it, the author reserving the more positive conclusions for a subsequent report. A paper on the *Stem Pessary* by the same author follows. These comprise all the papers presented to the section. Other topics of interest to members of the section were discussed, the proceedings of which seem to have been below the usual standard.

The Section on State Medicine was fortunate in having for its chairman, Dr. J. S. Billings, of the United States Army. This section and the one on Medical Jurisprudence, Chemistry and Psychology has been united. In the proceedings of this section we notice appropriate resolutions upon the death of the late Dr. William M. Compton, formerly Superintendent of Mississippi State Insane Asylum. During one of the sessions of the section, a series of resolutions was presented by Dr. S. E. Chaillé, which was transmitted to the General Association, with the recommendation of the section for adoption. These resolutions look toward some radical changes in the plan of the Association. They look, first, toward placing State, District and County Medical Societies, more fully under the control of the National Association, requiring from these societies certain specified annual reports or returns. Second, the resolutions contemplate the substitution of a periodical medical journal for the present annual volume, after the example of the British Medical Association. And third, certain changes in the election and eligibility of members of the Association. The resolutions were adopted, and Drs. S. D. Gross, N. S. Davis, Foster Pratt, A. N. Bell and Alonzo Garcelon, were appointed to take them into consideration and report at the next meeting.

The proposal to publish an official Journal of the Association may not be carried into effect, but we would suggest that something be done to decrease the ponderous size of the annual volumes, and to increase the intrinsic value of the material published. The address of Dr. Billings is replete with valuable facts and suggestions, some of which have an intimate bearing upon the approaching U. S. Census.

In this volume are published, for the first time, the minutes of the Section on Ophthalmology, Otology and Laryngology, and the papers read evince the propriety of organizing this section. Dr. Moses Gunn, of Chicago, the chairman of the Section on Surgery and Anatomy, discusses in his address the subjects of suppuration, the antiseptic system of Lister, and kindred topics, and presents to the association and surgeons generally some food for reflection. The papers before this section are carefully prepared, and in the main creditable to the Association. We hope that the time will come when the fact of a paper having been read before the American Medical Association will be *prima facie* evidence of its intrinsic merit; in other words, when a more strict censorship will be exercised over the contributions to the transactions.

The prize essay embraced in this volume is by Dr. Allan McLane Hamilton, "On Certain Forms of Primary and (local) Secondary Degeneration of the Lateral Columns of the Spinal Cord, with Especial Reference to an Infantile Rare Form." This article is illustrated by drawings of cases and sections of the cord. One of the latter, colored, fails to show the pathological condition in a degree sufficiently plain to make it of great value. The essay is well written, and the conclusions drawn with evident care.

*Sixth Annual Report of the State Commissioner in Lunacy:* 1879. JOHN ORDRONAUX, M. D., LL. D.

Dr. Ordronaux, the Commissioner, presents an interesting report to the Legislature. In treating of the medical aspects of insanity, he says that it is only by considering insanity a bodily disease, that the State can take legal cognizance of it. "The State can only deal with human bodies wherever it applies physical restrictions upon liberty, or afflictive personal penalties. It can not punish or restrain the mind, except in connection with the body." As regards the efficiency of State provision for the insane, no better commentary can be made, it is claimed, than the fact that though the statistics show an increase during the year of over *nineteen* per cent, the mortality fell to less than *eight* per cent. This also demonstrates that there will be such an increase in the total number of the insane, the ratio of increase to mortality remaining the same, that within the next five years all the completed asylums and those in process of erection will be filled to overflowing, and additional means of care must be provided, either by building a new series of asylums, or by enlarging those already in operation. Under the head of "Political Economy of Insanity," the Commissioner shows the impracticability of fixing upon any unvarying scale of per capita cost in the institutions of the State. This arises from the different circumstances of location, character of care demanded by different classes of the insane, the varying stages of completion of institutions, the numbers of the insane to be cared for, &c. "The prime factor in the problem which consists of the number of the insane and the character of their wants, can never be ascertained in advance." "There are no means by which uniformity in expenditure can be absolutely maintained." As showing the working

of the present lunacy law, the statement is made that at least 2,000 lunatics have been committed under its provisions to our various asylums, and no official complaint of the insufficiency in any respect has yet been made."

The Commissioner, after stating the delays which may be interposed to prevent summary action on his part to redress wrongs in case of the insane, asks for such amendments as will enable him to exercise his official powers without delay, and according to the emergency which may arise. He also recommends the appointment by the Supreme Court, of one or more Masters in Lunacy, in each judicial district. These should be counsellors at law, of at least two years' standing, and it should be the duty of the court to appoint some one of them on each and every commission or traverse in lunacy, as the chief commissioner or referee, before whom such issue must be tried. "By such means, we shall be educating a body of lawyers for trying these most difficult questions in every county in the State, and thus preparing the way for a cheaper determination of questions of lunacy than can now be obtained." The disposition of counties to care for their own insane, owing largely to the repletion of the State asylums is noted. The entire separation of the insane from the poor department of the county, is strongly urged.

The present provisions of the law, granting the State Board of Charities power to exempt from the operation of the Willard Asylum law, is sometimes rendered nugatory by the action of the counties in gaining from the Legislature, authority to care for their own insane. This has been done in some cases when the privilege has been denied by the State Board, where the means provided has not been deemed adequate for the care of

the chronic class. The case of Clinton county is cited as in point. The need of a hospital for epileptics is again urged upon the attention of the Legislature.

The question of the employment of the insane was investigated, and returns made from the State asylums and from some of the city institutions furnish the statistics of labor presented. In several instances, a money valuation is attached, but there would seem to be no uniform principle of estimating the pecuniary profit derived. The Commissioner presents a report of his action which was invoked in the case of the Kings County Lunatic Asylum. This is followed by a report to the Legislature, on the relations to the State, to the Society of the New York Hospital. The recapitulation of the statistics shows that there are 8,112 insane, 813 idiots, 576 epileptics; a total of 9,501 patients in the various institutions of the State.

*Third Report of the Board of Health to the Honorable City Council of the City of Nashville, for the two years ending December* 31, 1878. Nashville, Tenn.: 1879.

This report consists of twelve interesting and valuable documents, some of which deserve more extended reading than the limited circulation of the Health Board Report will give them. The Health Officer, Dr. J. Berrien Lindsley, opens the volume by a "Report on Sanitary Progress in Nashville, with Mortuary Statistics for 1877 and 1878." This report shows a gratifying progress in the sanitary condition of the city, and claims a reduction of the death rate from thirty-four per thousand per annum to seventeen per thousand, which is truly an end worth striving for.

Following this report is a paper by Dr. Thomas L. Maddin, entitled a "Plea for Sanitary Reform," having special reference to pure air and water. Articles three,

four and five are reports from various persons and committees upon the water works of Nashville, and are principally of local interest. These are followed by well arranged statistical tables, embracing information upon the various topics treated in the report. The Board of Health evidently consider it part of their duty to educate the people of Nashville upon all topics bearing upon sanitary science, for in this report they have presented papers upon the "Sanitary Geology of Nashville," by Prof. Alexander Winchell; upon "Trees and Shrubbery," by Dr. August Gattinger; on "Mental and Physical Hygiene of Public Schools," by Dr. J. Berrien Lindsley; on "Heating and Ventilation of Public Schools," by N. T. Lupton; and a "Report on the Prevention of Yellow Fever in Nashville in 1878," by the Health Officer, Dr. Lindsley.

We have contented ourselves with a running list of the contents of this report, and have not endeavored to comment upon any of the papers, although some of them are of considerable interest.

*Neurotomy of the Superior Maxillary Branch of the Trigeminus, for the Relief of Tic Douloureux.* FREDERIC S. DENNIS, M. D., Demonstrator of Anatomy, Bellevue Hospital Medical College. [Reprinted from the *New York Medical Journal*, June, 1879.]

This is an exhaustive monograph upon the subject. It gives the history of the operation, and of the experiments which led to its adoption. Twenty-one cases are reported, more than half of them by American surgeons. The results show that no case of death occurred, and that temporary relief was obtained in all the cases collected, and permanent relief in sixteen. This establishes the propriety of the operation, and shows, in cases where the diagnosis is correctly made, a gratifying success, which may well lead to its general employment for the relief of this painful affection.

## SUMMARY.

—Dr. William Hailes resigned the position of Third Assistant Physician in this Institution at the close of the year, and has resumed the practice of his profession in Albany.

—Dr. William W. Strew has resigned the Superintendency of the New York City Asylum, (Blackwell's Island). Dr. A. E. Macdonald, the Superintendent of the City Asylum, (Ward's Island), has been appointed to fill the vacancy thus created. He retains his former position, and is now the Superintendent of both city asylums.

—The Commissioners of Charities and Corrections of New York have appointed the following physicians as a consulting board to the city asylums under their care: Drs. James R. Wood, Austin Flint, Jr., E. G. Janeway, M. A. Pallen, A. McL. Hamilton, C. I. Pardee, J. P. P. White, A. L. Loomis, Whitman V. White.

—Dr. A. M. Fauntleroy has been appointed Superintendent to the Western Lunatic Asylum, of Virginia, at Staunton, in place of Dr. R. F. Baldwin, deceased.

—Dr. A. T. Livingston, formerly of the staff of this Asylum, is prepared to receive a few special cases of insanity or nervous disease, at his residence, No. 260 South Sixteenth Street, Philadelphia, Pa.

—Dr. Lauder Lindsay has resigned the Superintendency of Murray Royal Asylum, at Perth, Scotland, and has located at No. 9 Merchiston Ave., Edinburgh. He

was compelled to make this change from ill health, the result of a quarter of a century's continuous service.

—Prof. Charcot and Dr. M. G. Echeverria, of Paris, were elected honorary members of the British Medico-Psychological Association at the last annual meeting. Dr. Echeverria has also had the same honor conferred by the Societé Medico-Psychologique, of France. He was one of the Vice Presidents of the last International Congress de Médecine Mentale, at Amsterdam. His residence is 17 Rue Boissy, des Anglais, Paris, France. During a hurried business trip to this country recently, we had the pleasure of a call from him.

—In our review of the fourth edition of Bucknill & Tuke's Psychological Medicine, in October last, we omitted to mention that Lindsay & Blakiston, of Philadelphia, were the publishers in this country. We take pleasure in making the correction, and acknowledging the receipt of a copy of the work from them.

—Dr. A. H. Knapp has resumed the Superintendency of the Lunatic Asylum, at Ossawatomie, Kansas, a position formerly held by him.

*Credibility of the Testimony of those who have Recovered from Insanity, to Occurrences which took place during its Existence.*

In the decision of Judge Shipman, overruling the motion for a new trial in the case of Nancy J. Newcomer vs. Dr. Edward H. Van Deusen, reported in this number of the JOURNAL, the subject of the competency of the testimony of recovered patients regarding occurrences which took place during their attacks of insanity, is passed in review, and the legal principles involved are so clearly stated that we do not hesitate to reproduce the remarks of the judge in this place.

But the force of all testimony depends as much upon the ability of the witness to observe the facts correctly, as upon his disposition to describe them honestly. Generally, a period of insanity has always been considered at law, as one of civil death, from which no *prima facie* testimony could be elicited, and certainly in every case great doubt must necessarily attach itself to the evidence of a person who, having recovered from a state of insanity, seeks to testify to facts occurring during its existence, and if it appears that the mind of a witness was in such a condition that it could not correctly observe or retain passing events, or in other words, at the time the events occurred, the witness had no mind to understand, or memory to store up and retain them, he can not be called a competent witness. Each case must depend upon its own circumstances, however, for a large proportion of people recovering from insanity, can recollect what occurred when insane, and correctly separate the truth from the delusion. Nevertheless, the law seems to be settled, that persons of "non-sane memory," or who have not such an understanding as enables them to retain in memory, the events of which they have been witnesses, are excluded from giving evidence in courts. Wharton states the rule thus: "If the witness appears on examination by the judge, or by evidence *aliunde* to have been incapable *at the time of the occurrence which he is called to relate, of perceiving*, or to be incapable at the time of the trial of relating, then he is to be ruled out." (1 Wharton's Ev., § 403, § 402, § 404, and cases cited in notes; 1 Best's Ev., § 147, § 150 and notes.) It may, at times, be difficult with certainty to find and fix the varying frontier which separates sanity from insanity in the case of witnesses afflicted with delusions; for a man may have many delusions, and yet be capable of narrating facts truly, and in all such cases, the delusion is allowed to extend only to his credibility, and not to his competency. But when a witness could not have known what happened, it is obvious he is not competent to testify to events taking place in his presence. A blind man may testify to what he heard, but not to matters only perceptible to those having sight, and a deaf man to what he has seen, but not to sounds. A witness can not testify to what occurred while he was asleep. An idiot is not a competent witness, where the incapacity of perception is total. No matter from what cause, if a person be incapable of understanding or recollecting occurrences which he is asked about, he is not a competent witness upon those subjects. Competency is exclusively a question for the court. It must be determined by the trial judge, from his own

observations of the witness during the trial, and the testimony of the other witnesses in the case. (1 Wharton's Ev., § 391 et seq.) Commencing several months previous to the time Mrs. Newcomer went to the Asylum, in October, 1874, a number of witnesses testified that in their opinion, she was then sane. These lessened in numbers and force, however, as the month of October was approached. On the other hand, many witnesses produced by the defense, testified in their opinion she was insane during the same period, extending down to the time she went to the Asylum. But during the time she was actually in the Asylum, the evidence practically is all one way. All trained and skilled observers who saw and examined her during the time she was there, testify in the most positive manner to her insanity, and their ability and integrity has not been assailed. There is no room for a possible doubt that the Superintendent, Assistant Superintendent and all the Assistant Physicians so regarded her, and that they had good reason to do so. A large number of witnesses without, and many within the Asylum also testified to specific acts which they saw Mrs. Newcomer do, and which were never done by a sane person. There is no reason to question the veracity of these witnesses, or to doubt their version of what occurred. In short, if any reliance whatever is to be placed upon human testimony, during nearly if not all the time she was there, Mrs. Newcomer was unconscious of what was going on around her, and of her own condition, although evidences of more active intellection existed during the latter part of her stay. But no part of the time was she capable, mentally, of making a contract or of transacting any kind of business, nor could she have committed a crime. It is also perfectly apparent that she could not be convicted of perjury, for any untrue statement made by her as a witness in this cause, in relation to matters occurring during the time she was in the Institution. Her mental condition was such as to entirely exculpate her.

## ERRATA.

Page 296, line 11 from bottom, read "*as* a matter."
Page 301, line 7 from bottom, read "*result*" after "inevitable."
Page 302, line 2 from bottom, omit "that."
Page 305, line 4 from bottom, read "*im*proper conditions."
Page 311, at top, put "II" for "I."
Page 325, first line, read "*where*" for "when."

AMERICAN
JOURNAL OF INSANITY,
FOR APRIL, 1880.

## MEDICAL JURISPRUDENCE.

BY ISAAC EDWARDS, LL. D.,

Late Professor of Personal Property, Contracts and Commercial Law; Law Department, Union University, Albany, N. Y.

A physician writing upon this theme, gives us a medical treatise on those forms of disease, injury and death which are most frequently the subject of judicial investigation; and a lawyer, on the other hand, gives us the rules of investigation, and the legal consequences springing out of these injuries and diseases. The one naturally deals with the science of medicine, and the other with the science of law; both modes of investigation, prosecuted with skill, give us the modern science of medical jurisprudence.

We take many things besides property and social advantages by inheritance. First of all we derive our physical nature from our ancestors, the size and strength of the body, our features and complexion, the color of the eye and the hair. We call the flaxen-haired Englishman of to-day an Anglo Saxon; and by that name we suggest the multitude of influences working through twice ten centuries to form the character. As a habit of thought, we tacitly recognize the hereditary type of the physical man. Our minds run back on the line of his descent, through the rugged English

history, for the trials and struggles and activities which have produced this bone and muscle. We consider the country and climate, and the manner of life which have united through so many generations to give us precisely this physical basis of life. We do not ignore, we go behind the moral forces bearing on his physical development, in quest of those material forces which have created this robust and hardy frame.

We are not here suggesting a theory, we are simply stating a well verified fact. The last word of ethnological science asserts, with a fearless appeal to history, that the populations of Europe, Asia and Africa were twenty centuries ago just what they are now, in their broad features and general distribution. So tenacious of structure, color, form and feature, are the different stocks or races of men. Descending to a more special view of the same truth, we have it on good authority that eighteen hundred years ago, the population of Britain comprised people of two types of complexion—the one fair and the other dark—one people red or fair-haired and large-limbed like the Germans, and the other of dark hair and dark complexion, and closely resembling the Gauls, the nearest people on the south; that these two people did not differ from each other in any important physical character; that in none of the invasions of Britain which have taken place since the Roman dominion, has any other type of man been introduced; that the Saxon invasion did not bring in a new type of people; that the Danes and the Norsemen who followed them only came to a kindred race; and that the conquest of William did not materially alter the relative strength of the dark and light complexioned races of Britain. This statement grows upon us greatly as we read, in a late critique of Mr. Huxley, that now, as in the age of Cæsar, the dark-complex-

ioned English people predominate in the western parts of England, while now, as then, the light or fair men predominate in the north and east sections of Britain, in spite of the admixture created by the marvelous movements and activity of modern times. Who can dwell upon these facts without perceiving the vigor of the latent force or law, in virtue of which the apparently superficial characteristics of race are transmitted through so many centuries. The persistency with which the race of Israel maintains itself, even to its physical peculiarities, through the ages, through the rise and fall of empires, under every sky, against all manner of persecutions and hardships, is thought to be one of the standing marvels of history. And it is certainly true that no race gives us a record of such enduring and conservative power; such capacity to withstand the modifications of time, circumstances and climate. But who can say that the race of Ishmael, the Bedouin Arabs, traveling over the deserts and dwelling in its fertile valleys and along the shores of "Arabia the blest," or the fair-haired German race in its emigrations and permanent seats, has not vindicated itself by an equal vigor, by an equal conservatism of the peculiarities of the race. We are not surprised that a high authority lays it down as a general law that the physiological character of a nation lasts longer than its language.

With all this uniformity we have, on the other hand, endless variety; to some extent one race blending with another, the dark complexioned with the light in the same family, infinite diversity in the same people. It is like what we see in the vegetable world, in trees, for example; the olive, the oak, the walnut, the beech, the maple; each keeps its organism and fiber with the tenacity of a living creature; each produces its like, its

seed is in itself; there is no change from one species into another within the range of history; the grain of the wood is the same, and the outer covering, age after age; and yet we find no two trees precisely alike in all the mighty forest.

We have, then, two great laws; a law of descent, working uniformity, and a law of development, working diversity or that individuality which is found in every form of life. By the first, the law of uniformity, the child inherits the form, structure and physical attributes of his ancestry; his bone and muscle and vital organs; the length and size of the body; the narrow or broad chest; and the relative size and strength of the internal organs, such as the lungs and heart, liver, &c.; the brain and nerves and temperament of the body. By common consent these physical organs are transmitted and modified by descent. We have families, and even large districts of country, remarkable for their tall and strong men; long-lived families, among whom length of days and temperate living is the rule; families among whom diseases of the lungs prevail; left-handed families; scrofulous families, and families afflicted with the gout or with rheumatism or with cerebral diseases. How long is this catalogue of evil heritages? Apply for an insurance on your life, and note well the questions you will be called upon to answer. Before you are half through the list you will find how many of your chances for an average life depend upon the bodily or physical conditions with which you were born. Apparently the questions are not framed on any scientific theory; but they are very searching, just the kind of questions the shrewdest man will ask, who is about to risk his money on your chance of life. He assumes that there are hereditary diseases; he examines you with just the same care as if your chance for a long

life depended solely upon your present condition and habits. He takes a description of your person as minutely as if he were going to advertise you as a runaway criminal. He inquires into your antecedents at a time when you had only a bare possibility of interest in this life. He measures you as if he were going to make you a suit of clothes or a coffin. He takes your weight, 175 pounds; your height, 5 feet 10 inches, the measure of your chest in its ordinary state, and when you breathe deeply—38 and 40 inches—the measure of your abdomen, your figure and gait or step, the relative size of your bones, your temperament, the color of your eyes and hair, your clear skin and firm muscle. Nothing escapes him; his inquisition is as keen as that of a lover, or that of Henry the Eighth when he inquired of his minister, Cromwell, so narrowly into the form and person of Anne of Cleaves.

We gain our true knowledge of physiology from our physicians; from those who make the study of the organs and functions of the animal economy a life work. From them we learn that the form and vigor of the organs and parts of the body are often transmitted, like property, by descent; that the form of the eye, and consequently the power of vision, is thus transmitted; that the size and strength of the lungs, and hence their capacity to resist disease, are very generally transmitted; that the heart, liver, kidneys and spleen are subject to the same law of inheritance; that the brain, with its wonderful mechanism and special aptitudes, including a liability to derangement, often goes down from father to son; that every formation of body, internal or external, and every modification of the senses—blindness, long or short sight, quick or slow hearing, absence or acuteness of smell—may be transmitted as family heritages. They go further than this; some of

them tell us that the vicious tendencies and habits of the parents, their indulgences and excesses go down upon the children with the power of an irresistible impulse; that the child is made a drunkard by the liquor which his father drank before he was born. They appall us, as they coolly pile fact on fact in demonstration of the fearful truth; more terrible than the doctrine of inherited sin, because wrought into the very texture of the body, into the marrow of our bones. They even tell us, some of them, that malformations may be transmitted; like a hunchback, or strabismus, the squint eye; or, in horses, ring-bones and spavins. We are somewhat relieved on this point when a learned writer, Dr. Elam, tells us these aberrations from the normal type are not common, since docked horses and cropped dogs bring forth young with entire ears and tails.

What do our physicians mean when they tell us that certain diseases are hereditary? As a general fact, they do not mean that they are literally transmitted by inheritance. Apoplexy, calculi and gravel in the bladder, and gout are called hereditary diseases; and they are so in about the same sense as morals and manners are hereditary. The same habits of life produce the same results. Rich food, stimulating drinks, and a luxurious and sedentary life create an unnatural habit of body; they bring upon the offender the disease which results naturally and directly from his manner of life. A full plethoric habit is said to indicate a tendency to apoplexy, and yet it is well known that this form of disease often seizes men of a lean and spare habit. Stone and gravel and gout, arising from different causes, are said to be hereditary; and they are frequently found, generation after generation, in the same family. The same is true of intemperance; the

habit of indulging in spirituous liquors is transmitted, and with it an impaired or weakened constitution. How far this weakness extends to the special organs of the body, such as the lungs, the heart, the liver or kidneys, can not be definitely ascertained; but it is certain, it is verified by universal observation, that health and vigor may be inherited, and that physical infirmities are transmitted from father to son, from mother to child.

The law assumes that insanity is an hereditary disease. Our rules of evidence proceed upon this theory. A man, indicted for a crime, interposes for his defense the plea of mental derangement at the time of the fact charged; and under this form of defense he is permitted to prove that this disease prevails in his family—that his great-grandfather was so afflicted. Three generations, a pretty good leap this, in time and in departure from the original blood. Let us reverse Franklin's table, in ridicule of the celebrated Society of the Cincinnati, and we shall find, assuming this law of inheritance to be strictly accurate and uniform, that a man stands just one chance in eight to inherit the disease of his great-grandfather; and if we carry back the calculation seven steps farther, making ten in all, he does not stand one chance in a thousand of inheriting the disease of his ancestor, ten degrees back in lineal ascent.

Now we are assured that in France and in England about one person in every 400, Scotland about one in every 450, and in this country about one in 500 is deranged. It is easy, therefore, to see that this theory of inheritance must not be pushed back too far, or else we shall communicate this assumed taint of the blood to the whole body of our people.

What is insanity? The physicians do not agree with our courts upon this point. The law holds a man

responsible for his acts so long as he has the capacity to distinguish between right and wrong. On the other hand, medical writers very generally maintain that insanity may exist where a man has the capacity to discern, but lacks the power of choosing between right and wrong. They distinguish between the intellectual perception of what is right, and the moral power of choosing it. They assume that a man's faculties may be so deranged that, though he perceives the moral quality of his acts, he is unable to control them, and may be urged forward by some mysterious pressure to the commission of acts, the consequences of which he anticipates, but can not avoid.

The criminal law rejects this theory. It refuses to admit the existence of what is called impulsive insanity.* It affirms and enforces the restraining power of the will and conscience; and whatever may be said in criticism of its severity in rare and unusual cases, every one must see how impossible it is to frame a law to excuse deeds of violence and blood, because committed under some blind and irresistible impulse. The debatable land between mad passions and blind impulses unto crime, and the deeds of iniquity that spring from them, is confessedly very narrow.

> Between the acting of a dreadful thing
> And the first motion, all the interim is
> Like a phantasma, or a hideous dream:

It is not the object of the law to palliate and excuse, but to repress the passions.

What is insanity, this unsoundness of mind? It is a sickness, a disease. Here the law agrees with the physicians. It is a disorder, a derangement of the mind. Excluding cases of dementia, or loss of mind and intellect, the true test of insanity is delusion.

---

*52 N. Y., 467, People v. Flanagan, killing his wife.

[Austin v. Graham, 29 Eng. Law and Eq., 38.]

An Englishman, living long in India, became familiar with Eastern habits and superstitions, avowed himself a Mohammedan, and after his return to England was known among his friends as Hindoo Graham. On his death he left a will, giving several legacies, and the residue of his property to the poor of Constantinople, and towards erecting a cenotaph in that city, inscribed with his name, and having a light perpetually burning in it. The Prerogative Court, on these facts, held the will invalid. On a review in the Privy Council it was held that the facts were consistent with sanity of mind, there being no delusion or other proof of mental disorder. He labored under a delusion, according to the faith of the Christian world; but not that kind of delusion which the law regards as the test of insanity.

In a late case, which arose in the City of New York, the testator labored and made his will under the belief that his wife was conspiring with his relatives to break up his family, and kill him in some secret way, and Chief Justice Denio laid down this as the rule of law: "Where a person persistently believes supposed facts, which have no real existence, except in his perverted imagination, and against all evidence and probability, and conducts himself, however, logically upon the assumption of their existence, he is, so far as they are concerned, under a morbid delusion, and delusion in that sense is insanity." The testator had disinherited his family in favor of some charitable institutions.—33 N. Y., 619, 624.

In border cases it is difficult to say what is sanity, and what is insanity. "No one can say where twilight begins or ends, but there is ample distinction between day and night." Beyond a question there are cases where reason, the light of the mind, is lost as imperceptibly as the day declines into the night; cases where the moral vigor of the mind is diminished so slowly that it is almost impossible to tell when it passes the line of responsible action; cases of insanity which are not marked by any well defined delusion.*

An uncontrollable frenzy, arising from drunkenness, is not regarded as a disease. The law can not con-

* Haviland v. Hayes, 37 N. Y., 25; 15 Wal., 580.

sider it as the least excuse for crime, because it is voluntary and because every one owes it as a sacred duty to himself and to society to preserve his capacity for sane and rational action. And yet this rule, founded upon motives of public policy, is not enforced against a man who is afflicted with the *delirium tremens**—a disease brought upon him directly by his intemperance, and by the law treated as a confirmed malady, with the forbearance due to the infirmities of men.

In its origin, what is insanity? Is there such a thing as mental derangement, not connected with some physical disease? We come here upon a question of profound interest. The mind is united with the body; how united no science is able to explain. The mind acts upon the body, and the body upon the mind. Can the reason be overthrown, or can the mind be deranged otherwise than through some disease of the body or brain? Our traditions are full of superstitions. It is true the word *lunacy* has been emptied of its original sense; but it is not true that we have thrown off all the superstitions that cluster about the subject.

In the melancholy and humorous Burton, we have among the Causes of Melancholy, a subsection entitled, *Parents a Cause of Propagation.*

"That other inward inbred causes of Melancholy is our temperature, in whole or part, which we receive from our parents. * * * Such as the temperature of the father is, such is the son's; and look what disease the father had when he begot him, his son will have after him; and is as well inheritor of his infirmities, as of his lands. And where the complexion and constitution of the father is corrupt, these, saith Roger Bacon, the complexion and constitution of the son

* 18 N. Y., 9, 14, People v. Rogers.

must needs be corrupt, and so the corruption is derived from the father to the son. * * * Selencus had an anchor on his thigh, so had his posterity. Lepidus in Pliny was pur-blind, so was his son. That famous family of Ænobarbi was known of old, and so surnamed from their red beards." He then goes on to speak of the Austrian lip and the Bavarian chin as a species of heir-loom, always descending in the family.

We are not, fortunately, bound to regard this quaint old writer as an authority in science, because it would certainly embarrass us to digest those separate subsections wherein he shows how bad angels and witches and magicians, and the stars in their courses, become fruitful sources of melancholy; sources which have very much faded out of our modern scheme of things.

In 1843, thirty years ago, 276 persons were received into the Asylum at Utica; and in the analysis of the causes of derangement given by the Institution, we have this relative statement: moral causes, 128; physical causes, 93; unascertained causes, 55. From that time down to the year 1866, the number of cases classified as resulting from moral causes, steadily diminished. In that year, out of 388 cases, there were only twelve mentioned in which the mental derangement was attributed to moral causes. From the year 1866, the Institution has ceased to attribute the disease to moral causes. In other words, it no longer credits the notion that the mind can be thrown into derangement, except through some physical disease.

In his address before the State Medical Society, in February, 1871, Dr. Gray uses these words: "We say that insanity is a bodily disorder; that it is a disease of the brain. This does not imply that there is something to be thrown off, in the character of some morbid entity. It simply means that certain changes have

taken place in the brain, or in its investing membranes, which imply a departure from healthy physiological action, and that in consequence of these changes, there is more or less prolonged disturbance of the mind." He does not deny that moral causes may operate secondarily through the emotions, to produce the physical disease. For in another place he says: "In insanity we have the dominating organ always deranged in function, if not further. Whatever the cause may be, physical or mental, or whether the brain is primarily or secondarily affected, the condition in insanity is cerebral disease. Disease is what we have to deal with; not disease of mind, for the mind, the spiritual principle, the immortal being can not be the subject of disease. The manifestations of the mind are disturbed when the brain, which is its organ, suffers." Disease of mind is thus relegated into the field of superstition.

As a lawyer, I do not assume the burden of original investigation into the causes of insanity. The subject belongs to our physicians, because it involves an inquisition into the abstruse operations of diseased organs upon the mind. A subject of great and vital interest, because it relates to a disorder which is increasing under the rush and pressure of our modern life.

The form in which Dr. Gray states the results of close observation, is very interesting. He gives us these propositions:

1st. Disease of any part of the organism, may be the pathologic cause of insanity.

2d. In such cases, insanity is not manifested until the brain is actually involved.

3d. Disease of the brain or its membranes may be the primary, exciting cause of insanity, and other parts of the organism subsequently become affected.

4th. Insanity more frequently has its primary origin in pathologic states outside the brain, than in primary diseases of the brain.

These causes outside of the brain are of deep interest; they affect the general health, they touch the vital processes of nutrition, the marvelous scheme by which the tissues of the body are constantly removed and renewed, the process of digestion by which food is converted into healthy blood, the circulation by which the blood is purified in its passages through the lungs and excretive organs, and above all, the vital action by which each organ and artery and muscle and nerve is reinforced with new vigor. What is this but a continual act of creation—the inscrutible chemistry of life? Conceding the prevalence of these causes outside of the brain, and it follows that a tendency to mental derangement is not generally transmitted, except in the form of increased liability to some physical disease, or some derangement of the vital processes. It follows that the mind depends for its natural action much upon the health of the entire body; that the brain being the organ through which it acts, its action becomes unnatural when the brain itself is diseased or left without due nourishment; that it fails to be duly nourished when the vital processes are so far disordered that they cease to create healthy blood with which to nourish the brain: that insanity is no more hereditary than a disease of the liver; that if it be hereditary in any sense, it is so only so far as the vital organs are transmitted with their special aptitudes and liabilities. The ancient thought is still the best expression of true science—the thought which connects by a natural law *a sound mind with a sound body.*

# HYOSCYAMIA IN INSANITY.*

BY JOHN P. GRAY, M. D., LL. D.,
Superintendent New York State Lunatic Asylum.

For a number of years we have, from time to time, as the opportunities in this Asylum presented, made special study of certain remedies, to determine, as far as possible, their therapeutic value and their application to the conditions of the insane in the various forms and stages of the disease. Thus we have made careful study of conium and its preparations, of ergot, of phosphorus and phosphoric acid, and of chloral.

Hyoscyamus has long been recognized as one of the most valuable remedies in certain states of cerebral irritability and consequent mental excitement. We have used for many years the tincture of the leaves and seed, and the fluid and solid extracts, with great benefit. When hyoscyamia was announced, we at once procured it, and have since used it largely, internally and by hypodermic injection. It is safe, reliable and effective in small doses—the sixth of a grain of the dark preparation of Merck, (sometimes called hyoscyamin,) or the one-twelfth of a grain of the white crystal, acting much quicker and with more certainty than the maximum dose of the tincture or extracts. In acute mania, and melancholia with frenzy, no remedy we have used has more efficiently and readily calmed the high nervous and muscular excitement, and brought a degree of mental tranquillity essential to securing nourishment and rest, as means of restoration. In certain cases of mania

* Read before the Medical Society of the State of New York, at its last annual meeting, February 5, 1880.

and melancholia, where the delusions have been of such a character as to influence the patient determinately to resist food, while at the same time the frenzy and excitement have been intense, its administration has almost invariably controlled the patient. While under its influence, such patients will take food more readily, and, if necessary to resort to the œsophageal tube, it will be easier and entirely safe to introduce the tube and administer the necessary food. In these cases, the remedy has tended to quiet the stomach and to give toleration of food. In some cases of persistent refusal of food, even for months, and determined efforts at ejection after administration, this influence has been very conspicuous, as in the following case:

Man, aged 28; single; merchant; entered the Asylum with a history of ill-health dating back some three years. He was emaciated and anæmic; circulation feeble; muscles soft and flabby; skin dry and harsh; bowels constipated; breath offensive. He was gloomy, reticent, and at home seclusive. He asserted that a conspiracy had been formed to wrest from him the title to certain property; that his friends and relatives had entered into this conspiracy; and he gave an incoherent statement of facts which led him to this conclusion. He denied his insanity, but said he was very forgetful, and that small things worried him. Prior to admission, he had made suicidal threats.

Measures were taken, both by diet and medication, to correct the disturbance of digestion and improve his general condition. He resisted, to a certain extent, all remedies, and after some three weeks he refused to take any food, and the use of the tube was required. At this time he denied his own identity; said he would jeopardize his property and life by eating. For six months both food and medicine were daily administered

# L. REICH,

**DIRECT IMPORTER OF**

# HUNGARIAN WINES.

These WINES have received the endorsement of the most eminent Medical men of the country, as is evidenced from the following letters of commendation which have been received:

This is to Certify, that I have examined Mr. L. REICH'S TOKAYER AUSBRUCH, TOKAYER MASLAS, and BUDAI IMP. I take great pleasure in commending these Wines to the Medical Profession because of their purity.

R. OGDEN DOREMUS, M. D., LL. D.,
Prof. of Chem. and Toxicology in Bellevue Hosp. Med. Col., and Prof. of Chem. and Physics in College City of New York.

We have used in our practice the Hungarian Wines sold by Mr. LORENZ REICH, who puts them on the market unadulterated, just as they are imported. To this fact we attribute their great value as a medicine in diseases where such tonics are indicated, especially in those which are intended by defective digestion and imperfect assimilation. We cordially recommend Mr. Reich and his Wines to our professional brethren.

J. MARION SIMS, M. D.,
Late Surgeon to the Woman's Hospital, N. Y.

ALFRED L. LOOMIS, M. D.,
Prof. of Pathology and Practice of Medicine Univ. of City of New York.

F. LEROY SATTERLEE, M. D., Ph. D.,
Prof. of Chem., Mat. Med., and Therp., in the N. Y. College of Dent.

STEPHEN SMITH, M. D.,
Prof. of Orthopædic Surgery, University of City of New York.

JAMES R. WOOD, M. D., LL. D.,
Emeritus Prof. of Surgery, Belle. Hosp. Med. Col.

LEWIS A. SAYRE, M. D.,
Prof of Orthopædic Surgery and Clinical Surgery, Belle. Hosp. Med. Col.

W. H. THOMPSON, M. D.,
Prof. of Mat. Med. and Therap., Univ. of City of New York.

LOUIS F. SASS, M. D.

C. HEITZMANN, M. D.

W. L. LITTLE, M. D., New York,
Professor of Surgery, University of Vermont.

J. LEWIS SMITH, M. D.,
Clin. Prof. of Diseases of Children, Belle. Hosp. Med. Col.

DANIEL M. STIMSON, M. D.,
Prof. of Surgery in Women's N. Y. Med. College.

HENRY D. DIDAMA, M. D.,
Prof. Theory & Prac. of Med., Syracuse; Pres. of N. Y. State Med. Society.

***Albany Medical College.***

JOHN SWINBURNE, M. D.,
Prof. of Fractures and Dislocations and Clinical Surgery.

ALBERT VAN DERVEER, M. D.,
Prof. of the Principles and Practice of Surgery.

JACOB S. MOSHER, M. D.,
Prof. of Medical Jurisprudence and Hygiene.

JOHN M. BIGELOW, M. D.,
Professor of Materia Medica and Therapeutics.

LEWIS BALCH, M. D.,
Professor of Anatomy.

SAMUEL B. WARD, M. D.,
Prof. of Surgical Pathology and Operative Surg.

EDWARD R. HUN, M. D.,
Professor of Diseases of the Nervous System.

JAMES P. BOYD, M. D.,
Prof. of Obstetrics and Diseases of Women and Children.

THOMAS HUN, M. D.,
Dean and Emeritus Prof. of the Institutes of Med.

S. O. VANDER POEL, M. D., LL. D.,
Prof. of Theory and Practice and Clinical Med.

***L. I. Col. Hospital.***

ALEXANDER J. C. SKEENE, M. D.,
Prof. of Med. and Surg. Diseases of Women and Children.

SAMUEL G. ARMOR, M. D., LL. D.,
Prof. of the Principles and Practice of Medicine.

***University of Penn.***

D. HAYES AGNEW, M. D., LL. D.,
Professor of Surgery and Clinical Surgery.

RICHARD A. F. PENROSE, M. D. LL. D.,
Prof. of Obstetrics and Diseases of Women and Children.

HORATIO C. WOOD, M. D.,
Prof. Materia Medica and Therapeutics.

JOSEPH PANCOAST, M. D.,
Emer. Prof. of Gen. Descriptive and Surg. Anatomy, Jeff. Med. Col.

JAMES B. WHITE, M. D.,
Prof. of Obstetrics and Diseases of Women and Children, Pres. of Fac. Univ. of Buffalo.

The Wines will be shipped to any part of the United States.

Physicians wishing to test these Wines will, on application, be furnished with an original bottle at half price.

## PRICE LIST.

| *Per Case of 12 Small Bottles.* | | *Per Case of 12 Large Bottles.* | |
|---|---|---|---|
| **Tokayer Ausbruch. 1866,** | **$30 00** | **Somlyai Impl. 1868,** | **$14.00** |
| **Tokayer Maslas 1866,** | **24.00** | **Budai Impl. 1868** | **12.00** |

NOTICE.—My Wines are not for sale in any drug store or by dealers. To be obtained only by direct application to

**L. REICH, 13 West 11th St., bet. Broadway & University Place, N. Y.**

# THE JOURNAL OF PSYCHOLOGICAL MEDICINE AND MENTAL PATHOLOGY.

EDITED BY

**LYTTLETON S. FORBES WINSLOW, M. D., D. C. L.,**

Lecturer on Mental Diseases, Charing Cross Hospital.

NEW SERIES, VOL. V., PART I.

CONTENTS, APRIL, 1879.




London: Bailliére, Tindall & Cox, King William Street, Strand.

Part 2, Vol. V., will be published in October, 1879.

**PRICE 3s. 6d.**


---

# C. T. RAYNOLDS & CO.,

SOLE AGENTS FOR

# DAVID B. CROCKETT'S

## SPECIALTIES.

**106 and 108 Fulton Street, New York.**

We have made arrangements with Mr. David B. Crockett, to manufacture for our house exclusively all goods formerly made by him, and would inform the public that none of his productions


can be obtained excepting through our house, or our authorized agents; the said David B. Crockett being the sole manufacturer of the following specialties:

## No. 1 and 2 Preservative, or Architectural Wood Finish,

## SPAR COMPOSITION,

## Car and Carriage Priming or Wood Filler,

### PAINTERS' COMPOSITION.

## COMPOSITION COATINGS OR PAINTS.

And all the above goods to be genuine must bear the Patented Trade Mark of the Inventor.

### LIST OF SPECIALTIES.

PRESERVATIVE No. 1, or ARCHITECTURAL WOOD FINISH. Directions for use.—Apply with brush, same as shellac, and let each coat dry well before applying another.

For finishing and preserving all wood in their natural beauty. Also the most durable article known for coating over grained work, such as Bath Rooms, Vestibule Doors, etc. PRICE PER GALLON, **$2.85.**

PRESERVATIVE No 2. Directions for use.—Have the work clean and smooth, and apply same as you would a fine finishing varnish.

The most brilliant interior finish known for churches, public buildings, and places where you wish a hard wearing surface, and as a finish over the No. 1. PRICE PER GALLON, **$4.75.**

## PRICE LIST

## David B. Crockett's Composition Coatings.

**C. T. RAYNOLDS & CO., Sole Agents.**

| | Per Gall. | | Per Gall. | | Per Gall. |
|---|---|---|---|---|---|
| No. 1 | $2 00 | No. 13 D. Vermilion | | No. 29 L. Vermilion | |
| No. 2 | 2 00 | No. 14 D. Green | $2 25 | No. 30 | $2 00 |
| No. 3 | 2 00 | No. 15 | 2 00 | No. 31 | 2 00 |
| No. 4 | 2 00 | No. 16 | 2 00 | No. 32 Marine Red | 2 75 |
| No. 5 | 2 00 | No. 17 | 2 00 | No. 33 | 2 00 |
| No. 6 | 2 00 | No. 20 | 2 00 | No. 34 | 2 00 |
| No. 7 C. Yellow | | No 21 | 2 00 | No. 35 | 2 00 |
| No. 8 | 2 00 | No. 23 Marine Black | 2 00 | No. 36 | 2 00 |
| No. 9 L. Green | 2 25 | No. 24 | 2 00 | No. 37 | 2 00 |
| No. 10 | 2 00 | No. 25 | 2 00 | No. 38 Inside White | 2 25 |
| No. 11 | 2 00 | No. 26 | 2 00 | | |
| No. 12 | 2 00 | No. 27 | 2 00 | | |

**USE**

## D. B. Crockett's Spar Composition,

**For Finishing FRONT DOORS, VESTIBULES, and all Places Exposed to the Weather.**

(EITHER ON GRAINED OR HARD WOODS.)

## Superior to Varnish, or any Article in use for such Purposes.

(Established in the United States in 1840.)

**Have been Awarded 3 Silver Medals, 4 Bronze Medals, and 6 Diplomas.**

# E. WHITELEY,

## Steam and Sanitary Engineer, and Machinist,

57, 59, 61 and 63, Charlestown Street,

**BOSTON, MASS.**

Patentee and Manufacturer of the most improved Apparatus for Warming and Cooking purposes, for Public Institutions, consisting of Ranges, for Coal or Wood, of extra strength, with Flues of extra size, and means of cleaning the same. Also,

### Patent Cast Iron Steamers, Plain or Jacketed,

**Round or Square.**

with removable baskets for vegetables, &c., with Copper or Galvanized Iron Covers, having Ventilating tubes, which convey the steam and odors from the kitchen. E. Whiteley's Celebrated Seamless

### Patent Cast Iron Jacket Kettles,

in one piece, no bolts or packing used. Best in the World.

**COPPER JACKET KETTLES,**

for Tea and Coffee, thickly tinned inside, with Cylinders for the Tea and Coffee, strong and durable, will bear 75 pounds of steam; 80 gallons can be made and drawn off clear in 20 minutes. See Dr. P. Earle's report for October, 1874.

### Portable Ovens, Steam Ovens or Brick Ovens.

All my work is made in my own shops, under my personal superintendence, and of the best material, and thoroughly tested and warranted.

I refer by permission to the following gentlemen:

| | |
|---|---|
| Dr. NICHOLS, of Washington, D. C. | Dr. P. EARLE, of Northampton, Mass. |
| Dr. J. P. GRAY, M. D., Utica, N. Y. | Dr. B. D. EASTMAN, Worcester, Mass. |
| Taunton Insane Asylum, Taunton, Mass. | Michigan Insane Asylum, Kalamazoo, Mich. |
| Eastern Lunatic Asylum, Williamsburg, Va. | Tewksbury Alms House, Tewksbury, Mass. |
| Dr. C. A. WALKER, South Boston, Mass. | Dr. CALVIN MAY, Danvers Insane Hospital, Mass. |

And many others.

Father and Sons have been engaged in this Business for Seventy-nine Years, forty in Europe, thirty-nine in United States.

Two Silver Medals were awarded for improvements in Cooking Apparatus, at the Mechanics Fair in October, 1874, and 1878.

Improved Ranges are now in use at the National Soldiers Home; Hampton, Va.; National Soldiers' Home, (Togas,) near Augusta, Me., State Insane Hospital, Northampton, Mass.; State Insane Hospital, Middleton, Conn.; Young's Hotel, Boston, Mass.; New City Hospital, Boston, Mass.; New City Homœopathic Hospital, Boston, Mass.; New Hospital, for Insane, Worcester, Mass; New England Hospital for Women.

# Bellevue Hospital Medical College,

CITY OF NEW YORK.

MEMBER OF THE AMERICAN MEDICAL COLLEGE ASSOCIATION.

SESSIONS OF 1879–'80.

THE COLLEGIATE YEAR in this Institution embraces a preliminary Autumnal Term, the Regular Winter Session, and a Spring Session.

THE PRELIMINARY AUTUMNAL TERM for 1879-1880 will begin on Wednesday, September 17, 1879, and continue until the opening of the Regular Session. During this term, instruction consisting of didactic lectures upon special subjects and daily clinical lectures, will be given, as heretofore, by the entire Faculty, in the same number and order as during the Regular Session. Students expecting to attend the Regular Session are recommended to attend the Preliminary Term, but such attendance is not required.

THE REGULAR SESSION will begin on Wednesday, October 1, 1879, and end about the 1st of March, 1880. During the Session, in addition to four didactic lectures on every week-day except Saturday, two or three hours are daily allotted to clinical instruction.

THE SPRING SESSION consists chiefly of recitations from Text-Books. This session begins on the 1st of March and continues until the 1st of June. During this Session, daily recitations in all the departments are held by a corps of examiners appointed by the Faculty. Short courses of lectures are given on special subjects, and regular clinics are held in the Hospital and in the College building.

## FACULTY.

ISAAC E. TAYLOR, M. D.,
Emeritus Professor of Obstetrics and Diseases of Women, and President of the Faculty.

JAMES R. WOOD, M. D., LL. D.,
Emeritus Professor of Surgery.

FORDYCE BARKER, M. D., LL. D.,
Professor of Clinical Midwifery and Diseases of Women.

AUSTIN FLINT, M. D.,
Professor of the Principles and Practice of Medicine and Clinical Medicine.

W. H. VAN BUREN, M. D.,
Professor of Principles and Practice of Surgery, Diseases of Genito-Urinary System, and Clinical Surgery.

LEWIS A. SAYRE, M. D.,
Professor of Orthopedic Surgery, and Clinical Surgery.

ALEXANDER B. MOTT, M. D.,
Professor of Clinical and Operative Surgery.

WILLIAM T. LUSK, M. D.,
Professor of Obstetrics and Diseases of Women and Children, and Clinical Midwifery.

A. A. SMITH, M. D.,
Lecturer on Materia Medica and Therapeutics, and Clinical Medicine.

AUSTIN FLINT, JR., M. D.,
Professor of Physiology and Physiological Anatomy, and Secretary of the Faculty.

JOSEPH D. BRYANT, M. D.,
Professor of General, Descriptive and Surgical Anatomy.

R. OGDEN DOREMUS, M. D., LL. D.,
Professor of Chemistry and Toxicology.

EDWARD G. JANEWAY, M. D.,
Professor of Pathological Anatomy and Histology, Diseases of the Nervous System, and Clinical Medicine.

## PROFESSORS OF SPECIAL DEPARTMENTS, ETC.

HENRY D. NOYES, M. D.,
Professor of Ophthalmology and Otology.

J. LEWIS SMITH, M. D.,
Clinical Professor of Diseases of Children.

EDWARD L. KEYES, M. D.,
Professor of Dermatology, and Adjunct to the Chair of Principles of Surgery.

JOHN P. GRAY, M. D., LL. D.,
Professor of Psychological Medicine and Medical Jurisprudence.

ERSKINE MASON, M. D.,
Clinical Professor of Surgery.

LEROY MILTON YALE, M. D.,
Lecturer Adjunct upon Orthopedic Surgery.

JOSEPH W. HOWE, M. D.,
Clinical Professor of Surgery.

BEVERLY ROBINSON, M. D.,
Lecturer upon Clinical Medicine.

FRANK H. BOSWORTH, M. D.,
Lecturer upon Diseases of the Throat.

CHARLES A. DOREMUS, M. D., PH. D.,
Lecturer upon Practical Chemistry and Toxicology.

FREDERICK S. DENNIS, M. D., M. R. C. S.,
WILLIAM H. WELCH, M. D.,
Demonstrators of Anatomy.

### Fees for the Regular Session.

| | |
|---|---|
| Fees for Tickets to all the Lectures during the Preliminary and Regular Term, including Clinical Lectures | $140 00 |
| Matriculation Fee | 5 00 |
| Dissection Fee (including material for Dissection) | 10 00 |
| Graduation Fee | 30 00 |

### Fees for the Spring Session.

| | |
|---|---|
| Matriculation (Ticket valid for the following Winter) | $ 5 00 |
| Recitation, Clinics and Lectures | 30 00 |
| Dissection (Ticket valid for the following Winter) | 10 00 |

For the Annual Circular and Catalogue, giving regulations for graduation and other information, address Prof. AUSTIN FLINT, Jr., Secretary, Bellevue Hospital Medical College.

THE

# AMERICAN JOURNAL OF INSANITY.

The American Journal of Insanity is published quarterly, at the State Lunatic Asylum, Utica, N. Y. The first number of each volume is issued in July.

Editor,

JOHN P. GRAY, M. D., LL. D., *Medical Superintendent.*

Associate Editors,

JUDSON B. ANDREWS, M. D.,
EDWARD N. BRUSH, M. D.,
SELWYN A. RUSSELL, M. D.,
} *Assistant Physicians.*

THEODORE DEECKE, *Special Pathologist.*

**TERMS OF SUBSCRIPTION,**

Five Dollars per Annum, in Advance.

Exchanges, Books for Review, and Business Communications may be sent to the Editor, directed as follows: "Journal of Insanity, State Lunatic Asylum, Utica, N. Y."

The Journal is now in its thirty-sixth volume. It was established by the late Dr. Brigham, the first Superintendent of the New York State Lunatic Asylum, and after his death edited by Dr. T. Romeyn Beck, author of "Beck's Medical Jurisprudence;" and since 1854, by Dr. John P. Gray, and the Medical Staff of the Asylum. It is the oldest journal devoted especially to Insanity, its Treatment, Jurisprudence, &c., and is particularly valuable to the medical and legal professions, and to all interested in the subject of Insanity and Psychological Science